

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

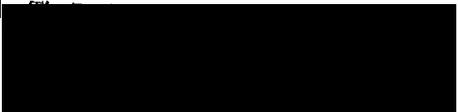
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	<p>INITIAL COMMENTS</p> <p>The following represents the findings of the California Department of Public Health during a Revisit survey. The revisit survey began on 7/29/13 and the date of exit was 8/9/13.</p> <p>Health Facilities Evaluator Nurses representing the Department: 14907 09671 16553 05008 16502 21752 18839</p> <p>Two representatives from the Centers for Medicare and Medicaid Services and a consultant participated in the survey.</p> <p>Census: 197 Core Sample size: 20 Clients added to the sample: 48</p> <p>Entity reported events intake numbers CA00363441, CA00363467, and CA00363731 were incorporated into the survey.</p> <p>CA00353441: Substantiated for failure to conduct a complete and thorough investigation and implement active treatment plans. See W154, W196 Client 74</p> <p>CA00363467: Substantiated for failure to ensure all allegations were reported immediately. See W153 Client 76</p> <p>CA00363731 was substantiated for failure to</p>	{W 000}	<p>W 000</p> <p>Entity Reported Incidents (ERI): ERI 353441</p> <p>a. The Unit Supervisor/designee for Client 74 will schedule a Special Interdisciplinary Team Conference to discuss conditions at the time of the incident for contributing factors to the behavior exhibited and determine whether a formal program for _____ is appropriate.</p> <p>b. The Psychologist/designee for Client 74 will schedule in-service training to Direct Care Staff (DCS) on Client 74's behavior plan with emphasis on identifying behavioral and environmental precursors including appropriate action steps.</p> <p>c. The Director of Quality Assurance developed and initiated a template for Facility Policy 5-05-5 Attach I - Guidelines For Completing Level 1 and 2 Review to assist DCS in identifying appropriate components of the General Event Report investigation including identification of behavioral plan steps implemented during the event.</p> <p>d. Program Management for Client 74 will schedule a review of the behavioral intervention at the Program Risk Management Review (PRMR) for appropriateness and correct implementation of the behavioral intervention.</p> <p>e. The Program Director/designee will review General Event Reports Level 1 documentation for required components and appropriate emergency behavioral intervention implementation.</p> <p>f. The Director of Quality Assurance/designee will monitor General Event Report Level 1 and 11 investigations for completeness.</p>	9/9/13 9/9/13 9/9/13 9/9/13
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> TITLE _____ DATE 10/15/13				

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 000}	Continued From page 1 Implement a health care plan. See W 331- Client 57.	{W 000}	ERI 363467	7/20/13	
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure the Condition of Participation, Governing Body and management, was met when four of seven Conditions of Participation were not met (Client Protections, Active Treatment, Health Care Services), and the governing body failed to take responsibility and action to identify and resolve systemic problems of a serious and recurrent nature. The facility failed to exercise, monitor and implement polices to ensure the health and safety of all clients residing at the facility. Findings: 1. The Condition of Participation, Governing Body was not met (See W104, W111, W120). A. The Governing Body failed to ensure all alleged violations were reported immediately, investigated thoroughly and corrective actions were taken. Policy 5.5.5 titled General Event Reporting and Guidelines (GER) to Completing Level I and II Reviews was not implemented as written to ensure complete and through investigations, analysis, corrective action, and notifications were conducted. (See W104)	{W 102}	 b. DCS conducted an assessment of all individuals on Client 76's residence for any observed injuries with findings provided to the Unit Supervisor for immediate follow up. c. The Unit Supervisor/designee on Client 76's residence provided in-service training to DCS who failed to report and document the event on Facility Policy 5-04-02 "Changes in Clients Medical Condition" and "The Physical Observation and Documentation Checklist" with emphasis on timely reporting to required disciplines and documentation requirements. e. The Shift Supervisor will monitor during daily rounds for injuries and notify the HSS and Residence Physician as appropriate. f. The Unit Supervisor/designee on Client 76's Residence will monitor documentation of injuries of unknown origin to ensure documentation requirements are complete and notifications are timely. g. The Agency Evaluation Committee/Governing Body will review findings and implement improvement plans as indicated. h. The Health Service Specialist on Client 76's residence will conduct a semi-annual audit of injury assessment documentation and will present findings to the Agency Evaluation Committee. i. The facility "Rounds Team" will monitor during rounds for injuries and report findings to the Agency Evaluation Committee. Results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.	8/8/13 8/17/13	

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{W 102}	Continued From page 2 B. The Governing Body failed to define admission criteria in Policy 1.9.1 titled Admission /Readmission and a draft policy /tool used by facility staff for preadmission screening was not approved by the Governing Body. (See W104) C. The Governing Body failed to ensure a safe, clean, environment and maintain Residences 31, 43, 44 and Goodell worksite. (See W104) D. The Governing Body failed to implement their policy for Documentation Guidelines for changes in condition, assessment and documentation for one client [REDACTED] (Client 198), and failed to maintain an accurate record keeping system (Clients 63, 163). (See W111) E. The Governing Body failed to assure Office of Protective Services officers met the needs of Client 114 when he was handcuffed on the facility campus. (See W120) 2. The Condition of Participation, Client Protections was not met. Individuals were subjected to physical, verbal and /or psychological harm and the facility did not take steps to prevent reoccurrence. Allegations of mistreatment, neglect or abuse as well as injurious of unknown source were not reported immediately, complete and through investigations were not conducted with appropriate corrective actions to prevent re-occurrences as defined by policy and in compliance with federal regulations were not taken. Individuals were subjected to the use of physical restraints and Individual freedoms were denied or restricted without consent or justification. Individuals rights were not promoted;	{W 102}	ERI 363731 a. The Residence Registered Nurse and Health Service Specialist assessed Client 57 [REDACTED] and documented findings in the Clinical Record. b. The Facility Governing Body developed and implemented new nursing procedures including 11.01 "Temporary Conditions", 11.02 "Client Injury Assessment and Intervention" and 11.03 "Change of Condition", and processes "Problem/TC/TSP Tracking Log", "Physical Injury and Documentation Checklist" and "Health Observations Change From Usual Self/Behavior." c. The Unit Supervisor on Client 57's residence provided in-service training to DCS on: the policies identified above, as well as Facility Policy 5.04.02 "Change of Condition", Nursing Procedure Manual 10.06 "Neurological Check / Neurological Assessment Flow Sheet", and processes "Problem/TC/TSP Tracking Log" and "Health Observations Change From Usual Self/Behavior" with emphasis on the need to provide ongoing [REDACTED] assessment and acute documentation every shift per protocol. d. Assigned DCS on Client 57's Residence will conduct a daily audit of the "Problem/TC/TSP Tracking Log" and Interdisciplinary Notes to ensure documentation of acute problems and Temporary Conditions and report findings to the Unit Supervisor/designee for follow up as needed. e. Unit Supervisor/designee will monitor the daily audit to ensure documentation is completed per protocol. f. The Rounds Team will monitor for compliance and results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.	7/29/13 8/9/13 8/13/13 8/15/13	

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{W 102}	<p>Continued From page 3</p> <p>to wear appropriate clothing, attend social and religious activities, ensure privacy during treatment and care of personal needs. The Individual Program Coordinator did not ensure active treatment programs were implemented, coordinated and monitored. Staffing and training was not provided in accordance with clients' needs and communications from family were not promptly returned. (See W124, W125, W127, W128, W129, W130, W136, W137, W138, W144, W149, W150, W153, W154, W167, W159, W186, W191, and W194)</p> <p>The survey team met with the Acting Executive Director, the Acting Clinical Director, and the Director of Agency Evaluation on 8/8/13 at 4:05 p.m. and two separate Incidents of IMMEDIATE JEOPARDY.</p> <p>On 8/9/13 at 1:35 p.m. the survey team accepted the facility's corrective action plan for both incidents of IMMEDIATE JEOPARDY. After review of evidence of implementation of the corrective action plan, the survey team abated the first incident of IMMEDIATE JEOPARDY on 8/9/13 at 1:35 p.m. with the Acting Executive Director, Acting Clinical Director, and the Director of Agency Evaluation.</p> <p>On 8/16/13 at 3:35 p.m., after review of evidence of implementation of the corrective action plan for the second incident, the survey team abated the IMMEDIATE JEOPARDY on 8/16/13 at 3:35 p.m. with the Acting Executive Director, the Director of Agency Evaluation, and the Standards Compliance Coordinator.</p> <p>3. The Condition of Participation, Active Treatment, was not met. Individuals were not</p>	{W 102}	<p>W 102</p> <p>FDC's Governing Body recognizes its responsibility to ensure the safety and well-being of the clients who live at FDC. Additionally, the facility is committed to the implementation of active treatment programs that focus on comprehensive assessment, information, development of a person centered plan, and consistent implementation/monitoring/revision of training plans. To this end, the Governing Body has implemented several significant system-wide changes to support this assertion. The facility is also working closely with two consulting groups (H&W Independent Solutions and the Consortium for Innovative Practices) to identify system-wide issues at the root cause level and to partner in the development of sustainable improvement plans. Specific plans of correction related to the system-wide corrective actions below are addressed under the appropriate tags.</p> <p>W102, #1</p> <p>a.</p> <ul style="list-style-type: none"> • Facility Policy 5.5.5 Attachment A -- Types of Incidents was revised to add falls/suspected fall (with or without injury) as an event that requires initiation of a General Event Report (GER). • Facility Policy 5.5.5 Attachment I -- Guidelines for Completing Level I and II Review was revised to include information specific to investigating falls/suspected falls. • A template was developed to prompt Level I reviewers with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions. 	8/30/13	9/09/13	9/09/13

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{W 102}	Continued From page 4 Involved in activities which addressed their individualized priority needs, individuals did not have opportunities to practice skills and to make choices in their environment, individual functional abilities have not improved and the facility did not identify barriers and implement a plan to minimize or overcome barriers. (See W194, W224, W227, W247, W249, W252, W255, and W279) 4. The Condition of Participation, Health Care Services, was not met. Individuals did not receive adequate health care monitoring and services and prompt treatment for acute health conditions; individuals did not receive medical treatment after a witnessed fall; individuals were not provided with nursing services in accordance with their needs; and individuals were not provided the opportunity to self-administer medications in accordance with their abilities (see W322, W331, and W371.) The cumulative effect of these systemic problems resulted in the facility failure to ensure the Governing Body was providing oversight and ensure the provision of safe healthcare and services.	{W 102}	W102, #1 • Nursing Procedure 11.01 Temporary Conditions and Nursing Procedure 11.02 Client Injury Assessment and Intervention were developed to prompt DCS to identify and report injuries or other changes in condition immediately. • The Agency Evaluation Dept. revised the General Event Reporting Tracking Log to include the event time in order to more accurately monitor that the 24 hour requirement for reporting to CDPH is consistently met. • An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body developed improvement plans for addressing identified issues. • The Program Risk Management Review (PRMR) meeting process has been fully implemented and has incorporated attendance by the Agency Evaluation Risk Manager/designee and IPC. This meeting includes a close review of OPS reports/investigations and/or other investigative reports, review of client injuries or other changes in condition, restrictive interventions utilized, cumulative data related to GERS, and other health and safety concerns. Improvement plans are established by Program Management to ensure clients are free from harm and that individual rights and freedoms are in place. • The revised process for Case Disposition has been fully implemented to ensure thoroughness of investigations and reconciliation of inconsistent facts.	8/09/13 8/12/13 8/09/13 7/01/13 7/01/13	
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and review of facility documents, the Governing Body failed to exercise, provide, monitor and/or revise policies and operating directions to ensure all alleged	{W 104}			

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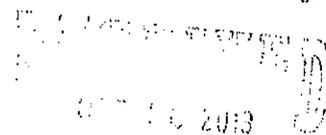
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{W 104}	Continued From page 5 violations were reported immediately, investigated thoroughly and corrective actions were taken. The facility failed to define admission criteria. The facility failed to maintain Residences 30, 31, 43, 44 and Goodell worksite in a safe and clean condition. A. Policy 5.5.5 titled General Event Reporting and Guidelines (GER) to Completing Level I and II Reviews was not implemented as written to ensure complete and thorough investigations, analysis, corrective actions and notifications were conducted. B. Policy 1.9.1 titled Admission /Readmission did not include admission criteria and a draft policy /tool used by facility staff for preadmission screening was not approved by the Governing Body. C. Residence 30, 31,43, 44 and Goodwell worksite was not maintained in safe and clean condition for the clients residing and working there. Findings: 1. Beginning on 8/6/13 a sample review from 42 GER's on Residences 28, 30, 41, 42, 44 and 45 dated 5/28/13 through 8/6/13 was completed. A GER is part of the facility system to initiate a collection of evidence, investigate and take corrective actions for an unusual occurrences such as injury of unknown source, and allegations of mistreatment, neglect or abuse. The GER process was revised on 8/13/13 to include specific instructions to facility staff when	{W 104}	<ul style="list-style-type: none"> The newly developed process for administrative investigation has been fully implemented to provide a mechanism for further investigation of events after the GER has been completed and the OPS investigation presented at Case Review. Training on the revised policies, nursing procedures, and new template was provided to DCS, nursing and medical personnel, and managers. b. <ul style="list-style-type: none"> Facility Admission Policy 1.9.1 Admission/Readmission was revised to address admission requirements. A Screening Tool was developed to assess clients for appropriate admission to FDC and to screen clients already admitted to FDC for their continued appropriateness. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. As identified, the IDT will make immediate adjustments to ensure the safety of others. The IDT will review and modify behavioral support plans as indicated and assess the individual's living arrangement to determine placement in the most appropriate setting. c. <ul style="list-style-type: none"> The current protocol for reporting the need for repairs on the residences/off-site training areas was revised to ensure better communication between residences and Plant Operations and to ensure that repairs are completed in a timely manner. FDC is in the process of purchasing a software program that will streamline the process for logging work orders. 	7/01/13 9/09/13 9/09/13 8/15/13 9/09/13 9/09/13 9/09/13	

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{W 104}	Continued From page 6 Initiating a GER and reviewing its contents. The revision include but was not limited to documentation regarding interviews with staff and client witnesses, staff accountability at the time of the event, behavior interventions tried, client response and activity occurring at the time of the incident. Guidelines for the Level I and II include an "investigation of the circumstances surrounding the event." The initial reporting, notifications, and medical reviews in the GER are reviewed for accuracy and completeness. GER's failed to consistently indicate complete and through documentation of the circumstances surrounding the incident, the active treatment occurring, staffing accountability and involvement, specific behavior interventions attempted and the client response as directed in the policy 5.5.5. The lack of complete and through documentation of the GER's impacted the ability of the facility to analyze the incident, revise plans and /or assure active treatment programs, supervision and adequate nursing care and services were provided. (SEE W153, W154, W157, W196, W331 for examples) 2. Record reviews beginning on 8/7/13 revealed Clients 65 and 77 received a staffing enhancement of one staff for the two of them for direct observation and program implementation 16 hours daily while awake. Despite staffing enhancements Client 65 had episodes [REDACTED]	{W 104}	<ul style="list-style-type: none"> Plant Operations initiated the hiring process for additional staff to assist with building maintenance and repair. A process was developed for partnership between the Energy Resource Specialist I and the General Services Administrator to conduct weekly maintenance environmental inspections. A QAPI was developed to monitor environmental and maintenance service.* d. Facility Policy 5.1.1 Clinical Standards of Care was revised to include a section on assessing skin integrity during client care. Nursing Procedure 11.01 Temporary Conditions and 11.02 Client Injury Assessment and Intervention were developed to set expectations and provide guidance to DCS regarding changes in a client's usual behavior or change in physical condition. A Problem/Temporary Condition/ Temporary Support Plan Log was developed and implemented to ensure DCS communicate and display continuity in documentation of identified health issues/injuries. Nursing Procedure 11.04 Daily Care Flow Sheets was developed and implemented, along with Daily Care Flow Sheets to provide a more efficient tracking mechanism for DCS to document important ADL services/supports throughout the client's day. A Physical Observation and Documentation Checklist was developed to assist DCS in assessing, notifying appropriate people, and documenting injuries. A Change In Usual Self/Behavior document was developed and distributed to residence staff to assist DCS to capably assess individuals on an ongoing basis. 	9/09/13 9/09/13 10/10/13 8/30/13 8/09/13 9/01/13 8/19/13 8/16/13 8/13/13	



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{W 104}	<p>Continued From page 7 Despite the staffing enhancement Client 65 and 77 continued to have episodes [REDACTED]</p> <p>Review of the policies titled "Admission /Readmission" and "Preadmission" dated 12-3/12 revealed the Clinical Director and / or Program Director may decide not to admit or deny admission on the basis the person does not meet admission criteria described in 1.9.1. The only description of admission criteria in 1.9.1 was individual must be in need of active treatment. There were no criteria for denial of admission listed in the policy.</p> <p>Interview on 8/7/13 at 1:00 p.m. with facility Program Director (PD) and Director of South Coast Regional Center (RC) Project revealed the RC was working on a "trailer policy with amendments specifically for acute crisis admissions." The RC and facility staff currently used a draft policy and tool for preadmission assessment of individuals. The PD verified the draft policy and tool had not been approved by the Governing Body for use. The draft policy and tool was designed by the RC and used by facility staff, it was titled " Short Term Crisis Admission and Stabilization Implementation Guideline - Acute Crisis at Fairview Developmental Center" dated 5/20/13.</p> <p>The PD indicated admissions could be denied and offered the following examples, individuals charged with a felony, drugs and alcohol problems, sexual offender history and court competency needs. A request for the admission and denial criteria revealed there was none. (SEE W127 and W194)</p>	{W 104}	<ul style="list-style-type: none"> • A Quality Assurance Performance Improvement (QAPI) log was established to monitor adherence to assessment and documentation protocols. • An ad hoc committee comprised of medical, health care, clinical and administrative staff was formed to adopt a comprehensive Falls Prevention program. • The Fracture/Fall Risk Assessment has been revised to focus on the falls aspect of assessment. It includes a scoring/weight aspect to assist the ID Team in identifying clients at moderate and high risk for falls and care planning accordingly. • Training on the revised policies, nursing procedures, and new log and checklist was provided to level of care staff, nursing and medical personnel, and managers. e. • A general event report (GER) is initiated by clinical staff, and thoroughly investigated by supervisors and managers any time OPS involvement is associated with a behavioral issue. • OPS Officers generate a police report that is reviewed and approved by the Commander. • The Governing Body reviews all instances of Law Enforcement Involvement (LEI) with the Commander/designee and makes recommendations as indicated. • The HRC Committee criteria for reviewing LEI was revised to be more inclusive of clinical and OPS investigations. • The Human Rights Committee (HRC) Manual was revised to include LEI in Behavior Emergencies. 	8/01/13	9/09/13

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 104}	Continued From page 8 Residence 44 Maintenance and Cleanliness of Residence 44: 3. During observations on 7/29/13 at approximately 9:30 a.m., the bathroom (Room 220) contained a sink area with laminate which was chipped off, and peeled back with exposed wood. The section was above the sink area, part of the backsplash, and extended at least one foot in length horizontally. 4. During observations on 7/29/13 at approximately 9:30 a.m., in the bathroom (Room 220), a toileting stall on the left had no rod to suspend the toilet paper from, increasing the possibility of toilet paper being placed on the floor by clients, thus increasing risk of infection. The toilet paper, at the time, was perched on a bar which extended out from the wall. During observation on 7/29/13 at 9:40 a.m., in the bathroom (Room 232) one stall had no rod to suspend the toilet paper and the toilet paper was perched on a bar which extended out from the wall. Both toilets contained excrement. During observation and concurrent interview on 7/29/13 at 10:05 a.m., an activity room had no toilet paper rod. The US stated toilet paper rods had all been replaced the previous Monday (7/22/13) expressed astonishment at how many rods were missing. During observation on 7/29/13 at 10:10 a.m., in bathroom (Room 264), there was no toilet paper rod. The bathroom smelled of urine. 5. During observation on 7/29/13 at approximately 9:45 a.m., Room 249 had a privacy curtain	{W 104}	<ul style="list-style-type: none"> A collaborative workgroup consisting of representatives from OPS, Governing Body, Managerial, and Clinical areas was formed to discuss delineation of clinical and police responsibilities during behavioral events that endanger self or others. <p>W102, #2</p> <ul style="list-style-type: none"> a. A Protection From Harm Manual was developed and distributed to all facility staff. The manual contains an overview of Client Protection principles as well as a hierarchy of processes in place to prevent and/or mitigate client risks and serves as a reference for managers/supervisors and DCS. b. Facility Admission policy 1.9.1 Admission/Readmission was revised to address admission requirements. The manual was introduced at a general employee meeting and FDC Bulletin. Topics from the manual will be included on the Focus Calendar. Managers/supervisors received orientation. c. A Screening Tool was developed to assess clients for appropriate admission to FDC and to screen clients already admitted to FDC for their continued appropriateness. d. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. As identified, the IDT will make immediate adjustments to ensure the safety of others. The IDT will review and modify behavioral support plans as indicated and assess the individual's living arrangement to determine placement in the most appropriate setting. 	9/09/13	
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{W 104}	Continued From page 9 suspended near the door which had approximately five to ten reddish-brown stains measuring approximately 2 to 6 centimeters in length. The toilet contained stool. 6. During observation on 7/29/13 at approximately 9:55 a.m., the laundry room (Room 213) smelled of urine. The US stated there was no dirty laundry presently in the room. 7. During observation on 7/29/13 at 10:12 a.m., Room 263 had two vents in the ceiling. The vents' grates were a dark discoloration and covered with thick dust. At 10:15 a.m. on 7/29/13, a housekeeping staff who was busy cleaning, stated that staff was supposed to "high dust and low dust" on a weekly basis. The housekeeping staff stated he had been sent over to clean this residence because the regular housekeeping staff was on vacation. The housekeeping staff looked for but did not find a list which would have instructed housekeeping staff on this residence what, exactly, was to be cleaned and when. On 7/29/13 at 10:30 a.m. the same housekeeping staff stated there were vents in other rooms which also had needed cleaning. On 8/8/13, review of a "Housekeeping Department Task List ...Residence 44," showed in a right hand column, a list titled, "8 Steps cleaning," under which was listed "High Dust." (Unsampled Client 71) 8. During observation and concurrent interview on 7/29/13 at 10 a.m. a dresser, whom the unit	{W 104}	e. Facility Policy 5.5.5 Attachment I – Guidelines for Completing Level I and II Review was revised to include information specific to investigating fall/suspected falls. f. A template was developed to prompt Level I reviewers with specific questions that will elicit a more thorough investigation of events. g. Nursing Procedure 11.01 Temporary Conditions and Nursing Procedure 11.02 Client Injury Assessment and Intervention were developed to prompt DCS to identify and report injuries promptly. h. The Agency Evaluation Dept. revised the Tracking Log for General Event Reporting to include the event time in order to ensure the 24 hour requirement for reporting to CDPH is met consistently. i. New facility policies 5.3.1 Behavior Support Principles (and Glossary), 5.3.2 Behavior Support Programs, and 5.3.3 Behavior Techniques and Interventions were developed and distributed. Policy 5.3.3 specifically addresses the expectation for applying restraints in a manner that protects clients' privacy and dignity. j. A summary of new and key items from the new facility behavior policies were distributed to DCS, emphasizing positive behavioral approaches. k. The IPC progress note format was revised to include a more cohesive analysis of progress/lack of progress. l. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty. m. The IPCs were added as participants to daily Program Management Meetings to identify and immediately address developing issues and trends for clients in their caseload.	9/09/13 9/09/13 8/09/13 8/12/13 8/28/13 9/09/13 9/01/13 9/01/13 8/26/13	

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{W 104}	Continued From page 10 supervisor (US) stated was used by Unsampled Client 71, was missing one of three dresser drawers. The US did not state or present documentation that a new drawer had been ordered as a replacement. 9. During observation and concurrent interview on 7/29/13 at 10:20 a.m., the US stated that the residence had a new refrigerator. A small refrigerator was on a table in a room used by clients. The refrigerator was opened and was warm inside. The US tried getting the refrigerator running, was unsuccessful, and said it was a faulty plug. 10. On 7/31/13 at approximately 10:20 p.m. one large plastic planter pot, in the Residence 44 patio, had a large hole with cracks radiating from the hole. The hole was approximately 4 to 5 inches and most of the numerous radiating cracks measured one half to one foot in length. 11. On 7/31/13 at 10:03 a.m., the door into the bathroom attached to Room 257 was noted to be on the right hand side (as one entered the room) in the corner closest to the distal wall. Against the wall to the left of the door was a bed which was flush against the wall with the foot of the bed near the bathroom door. When an attempt was made to enter the bathroom, the door had to be closed over halfway to walk around the partially opened door in order to enter the bathroom. The foot of the bed blocked the door from swinging freely so that the ability to enter and exit the bathroom was restricted. In the event of an emergency, the partially blocked passage would have created an impediment to accessing a client or exiting the bathroom quickly and safely. Goodell worksite - room 4	{W 104}	n. A family satisfaction survey was developed and will be available to families on an ongoing basis. The results will be shared with the Governing Body and improvement plans implemented to ensure ongoing communication with families and to ensure their needs and issues are addressed in a timely manner. o. Governing Body members are working with H&W Consultants to review access and informed consent processes to ensure that individual rights and freedoms are protected. p. The Access Support Consent process was revised to include the access support training plan in the consent packet. q. A schedule will be developed to review each person's access needs, initiate a new informed consent as indicated, and develop plans that promote individual freedoms and rights as indicated. HRC to schedule reviews of all access plans. r. • Unit Supervisors and Program Management Team meet daily to review the staffing needs for the next 24 hours, including using available staff, return to work staff, limited duty assignments. Adjustments are made as needed. • Nursing Coordinators review staffing assignments and deployments daily and make adjustments to meet residence acuity needs. • Each Program utilizes an after-hours staffing residence to secure staffing resources as needed. Program Management remains on call to resolve after-hours staffing needs. • Nursing Coordinators meet weekly to review facility staffing for the upcoming week and make plans for coverage as needed. • A weekly staffing projection report is provided to the Program Directors and Clinical Director for monitoring to ensure minimum staffing guidelines are maintained.	9/09/13 9/09/13 9/09/13	

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(W 104)	Continued From page 11 12. On 7/29/13 at 2:19 p.m., during an observation of the contents in the refrigerator at the culinary art class at the Goodell worksite-room 4, the following was observed: a. A large plastic bag of odorous vegetables. b. Three unlabeled and undated plastic containers that contained remnants of food. c. Three frozen black bananas and an undated frozen hot dog. d. Brown matter was observed on the bottom of the refrigerator. Goodell worksite-room 11 13. During an observation of the outdoor patio area at the Goodell worksite- room 11 on 7/30/13 at 10:20 a.m., the following was observed: a. Multiple cigarette butts and shreds of paper were observed on the ground. b. An open circular empty planter (built into the cement patio), approximately six feet in diameter and 6 inches deep, posed a potential accident hazard to clients that ambulated in the area. Residence 43 14. On 7/29/13 at 6 p.m., the surveyor asked staff to open the door to the room that contained restraints and helmets on Unit 43. Supervisory staff attempted to open the door and was observed forcefully pulling at the door knob multiple times and was unable to open the door. After a second attempt, another staff was again observed forcefully pulling at the door knob and was eventually able to open the door after numerous attempts. The door to this room had recently been painted and the door frame became stuck after the paint	(W 104)	r. • Program Directors review monthly residence schedules to ensure continuous balanced coverage. • Clinical and Administrative services review undelivered staffing monthly to develop action plans for undelivered staff. • Executive Director, Clinical Director, and Administrative Services Director review the staffing resources for the Center monthly to facilitate deployment of DCS. • Clinical Director initiated development of a work group with DCS representatives from each area to review staffing deployment and make recommendations to ensure staffing levels are met within the center. • The Program Directors initiated development of a protocol to provide a center wide staffing coordinator that will ensure scheduling of resources are effectively deployed to meet the minimum staffing guidelines and the acuity needs of the clients. • A Quality Assurance performance (QAPI) was developed to review staffing concerns. The results of this report are reviewed at the AB committee and improvement plans are implemented as indicated. • Vocational Services is being restructured and redeployed to Central Program Services with staffing supports to provide continuity within each vocational site and enhance client's skills for job placement opportunities. • Clinical Services initiated the process of hiring DCS to fill vacant positions.	9/09/13 9/09/13 8/01/13 9/09/13 9/09/13	

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{W 104}	<p>Continued From page 12</p> <p>had dried, potentially causing a delay in access to the restraints and helmets in an emergency situation. Staff present stated that they would put in a work order.</p> <p>15. During an observation of the outside patio area on 7/29/13 at 6:20 p.m. on Unit 43, the water fountain, used by clients, was soiled and contained plant debris. Paper debris was also observed throughout the patio area.</p> <p>Residence [REDACTED]</p> <p>16. During observations on 7/30/13 at 7:35 p.m. with the Licensed Shift Lead, a large metal bin which contained several food items, namely yogurt, milk, pudding, jello, and a sandwich were sitting on a cart in the employee room (a locked door). The food products were cool to the touch; however, there was no ice in the bin. (There is a risk of food contamination the longer the food products sit out unrefrigerated.)</p> <p>During an interview at that time, the Licensed Shift Lead stated that the food items were the clients' evening snacks and supplements. He stated that the snacks are brought to the unit by the dietary staff shortly after the completion of the clients' dinner meal. He stated that it was the responsibility of the residence staff to put the snacks/supplements in the refrigerator. He then proceeded to place the items in the refrigerator which, he stated was the employee refrigerator.</p> <p>Review of the policy, Health Care/Nursing Procedure Manual, Nursing Procedure Number: 5.04, Revised Date: 06/09, noted "Procedure 2. Supplements must be stored refrigerated appropriately if not provided to the client"</p>	{W 104}	<ul style="list-style-type: none"> • The facility "Rounds Team" (Governing Body, Program Management, Unit Supervisors (US), Shift Leads, Case Coordinators (IPC)) will monitor during rounds to ensure adequate staffing levels are provided based on client acuity. Findings will be calculated, analyzed by AE Analyst and presented to the AE Committee for action as indicated. 2s. • The Behavior Support Committee initiated development of a process for a facility-wide data collection system that provides more immediate recording of behavioral data. • The Senior Psychologist initiated development of accurate collection methods with training to be provided. <p>W102, Item 3</p> <ul style="list-style-type: none"> a. A new protocol was developed and implemented to address expectations related to quantity and quality of community outings. b. Active Treatment Coordinators have been designated on each Program and are responsible for the development and implementation of Active Treatment projects to be integrated facility-wide, with emphasis on promoting choices and independence in all environments. c. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues. d. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. e. A plan has been developed to reorganize Vocational Services under CPS, which will improve the continuity of services and promote more opportunity for choice as well as provide an increased variety of paid job opportunities. 	<p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/01/13</p> <p>9/01/13</p> <p>9/01/13</p>

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(W 104)	Continued From page 13 Immediately upon delivery". During an interview with the Unit Supervisor on 8/6/13 starting at 4:25 p.m., she stated that the snacks were stored in the employee refrigerator at that time due to the clients' refrigerator being defrosted. Residence 31 17. On 7/30/13 at 11:10 a.m., Client 184 [REDACTED] ran out of the back door of room 30 at the Activity Center onto an adjacent loading dock. The client stepped off the ledge as staff approached. This dock had no railings except for a portable wheel chair ramp which the client did not use. The distance from the ground to the ledge was approximately one foot. During an interview on 8/6/13 at 2:30 p.m., the classroom teacher stated that the clients do not use that exit and Client 184 had never gone out of that exit prior to 7/30/13. The client again exited this door on 8/6/13 and staff grabbed him by the left forearm and pulled him back into the room. 18. On 7/30/13 at 8:30 a.m., non-sampled Client 174, was out of his wheel chair, on the floor in the day room attempting to get into the restroom. Staff assisted the client however, shortly after the door was closed the light went out. The staff rechecked but there was no way to keep the light on longer. It appeared to be motion activated. There were no windows or other light in the bathroom. The staff stated that she would report the problem. On 8/6/13 at 2:30 p.m., the light was still not working. During a concurrent interview, the acting Unit Supervisor (U.S.)	(W 104)	f. CPS has developed a process to ensure that all vocational assessments are completed, adequately address the skill level, capabilities, preferences and needs of clients in paid vocational programs to increase their skill and productivity. g. CPS has developed a process to review the vocational program and establish an entrance and exit criteria for each vocational site. h. Training has been developed and a schedule established to educate DCS on expectations and implementation of self-administration of medication. i. An audit tool has been established for nursing staff to assess the implementation of self-administration of medication. j. A mentorship program has been developed between Program Management/Supervisors and DCS to ensure competent assessment of clients' capabilities, strengths and needs when completing the Independent Living Skills Assessment (ILSA) and to ensure their understanding of the self-administration of medication section in particular. k. A protocol was developed and implemented to include clients in facility menu planning. l. IPC documentation duties have been realigned to promote more emphasis on program coordination, integration and monitoring. m. The Rounds Team will monitor for compliance and results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed. W102, #4 a. The following facility policies were revised: 5.1.1 Standards of Care (skin integrity), 5.5.5 General Event Reporting Attachment A - Types of Incidents (injuries of unknown origin, falls), 5.5.5 General Event Reporting Attachment I - Level I and II Review of QERS.	9/01/13 9/01/13 9/09/13 9/09/13 9/09/13 9/01/13 9/01/13 8/30/13	

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{W 104}	Continued From page 14 checked the repair log and there had been no request to check the bathroom light nor had it been verbally reported to her. 19. On 8/7/13 review of the Client Protections General Event Reporting policy Number 5-5-5, Attachment A issued June 2013 page 1 defined: "Injuries of Unknown Origin - An injury should be classified as an "injury of unknown origin" when both the following conditions are met: a) The source of the injury was not observed by any person and the source of the injury could not be explained by the client and b) the injury is suspicious because of the extent of the injury, or the location of the injury (e.g. the injury is located [in] an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time, or the incidence of injuries over time." During an interview on 8/9/13 at 10 a.m., the Director of Agency Evaluation was informed of the identified injuries of unknown origin not reported. The Director was also queried regarding the section of the above facility policy that indicated that two conditions had to be met to qualify as an injury of unknown origin. The Director stated that the policy was newly revised and the governing body would need to review it. Residence 30 20. Staff did not know FDC policy requirements as evidence by night shift not signing-in with assigned breaks on 7/29/2013. On 7/29/2013 Staff verified that night staff did not sign for breaks as directed in Facility Policy 6.6.18 "Attendance and Staffing Guidelines" and the Daily Sign-in Record form. Formally assigned breaks for level of care staff during each shift	{W 104}	W102, #4 b. The following Nursing Procedures were developed or revised: 10.02 Helmet Usage, 10.06 Neuro Checks, 10.09 Vital Signs, 11.01 Temporary Conditions (new), 11.02 Client Injury Assessment and Intervention (new), 11.04 Daily Care Flow Sheets (new). c. A Protection From Harm Manual was developed and distributed to all facility staff. The manual contains an overview of Client Protection principles as well as a hierarchy of processes in place to prevent and/or mitigate client risks and serves as a reference for managers/supervisors and DCS. d. A Problem/Temporary Condition / Temporary Support Plan Log was developed and implemented to ensure DCS demonstrate continuity in documentation of identified health issues/injuries. e. A Daily Care Flow Sheet was developed and implemented to provide a more efficient tracking mechanism for DCS to document important ADL services/supports throughout the client's day. f. A Physical Observation and Documentation Checklist was developed and distributed to residence staff to assist DCS in assessing, notifying appropriate people, and documenting injuries or other changes in condition. g. A Change In Usual Self/Behavior document was developed and distributed to residence staff to assist DCS staff in more capably assessing individuals' care on an ongoing basis. h. The IPCs and Health Service Specialists (HSS) were added as participants to daily Program Management Meetings to facilitate identification of and immediately address developing issues and trends for clients in their caseload.	8/13/13 9/09/13 8/15/13 8/19/13 8/16/13 8/13/13 8/26/13	

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FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID		2501 HARBOR BOULEVARD COSTA MESA, CA 92628		
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(W 104)	<p>Continued From page 15</p> <p>located on the daily assignment sheet were not consistently completed. Pm shift again verified on 8/5/2013 Residence 30 does not have assigned break times during the night. Staff stated that they take their breaks when: "It's quiet." On night shift, staff independently determine the time of his/her break.</p> <p>Maintenance and Cleanliness of Residence 30</p> <p>21. Observation on 7/29/2013 at approximately 9:30 revealed missing door knobs to open closet doors with sharp screws exposed in client bedrooms 25 and 36. The Unit Supervisor, US verified that there was no system to address maintenance issues on 7/29/2013. In Room 36, 2 closets were broken.</p> <p>22. Dress drawers were off the track in Room 55. The US stated this could not be repaired and the entire unit of furniture, dresser, must be replaced.</p> <p>23. Drinking fountain handle to turn on water was missing rendering drinking fountains inoperable in Rooms 27 & 37 which were group gathering rooms for the individuals. Client 150 [REDACTED]</p> <p>Client 162 [REDACTED] (HSA) 8/4/13 as capable of drinking from a fountain and independently completes task.</p> <p>Outside Patio and back yard of Residence 30</p> <p>24: Observation on 7/29/2013 at approximately 10:00 revealed the following: Lattice on the ground was not installed as needed as verified by the US. Drinking fountain was filled with heavy accumulation of debris of dead grass and leaves. Eight soiled drinking glasses containing left over punch and a pitcher was outside in the yard. The US stated that staff left these items outside after</p>	(W 104)	<p>i. An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body reviewed the findings and developed improvement plans for addressing identified issues.</p> <p>j. An audit of DCS' adherence to Nursing Procedures 11.01 Temporary Conditions and 11.02 Client Injury Assessment and Intervention was conducted to ensure expectations are being met for assessment and documentation of injuries and other physical conditions.</p> <p>k. A Quality Assurance Performance Improvement (QAPI) log was established to continue monitoring of DCS adherence to assessment and documentation procedures.</p> <p>l. The PM&R Department conducted an audit of medical and behavioral helmets to ensure cleanliness, proper fit, and proper function. Repairs/replacements needed were initiated immediately.</p> <p>m. A Quality Assurance Performance Improvement (QAPI) log was established to continue monitoring of helmets. The Governing Body reviewed the findings and developed improvement plans for addressing identified issues.</p> <p>n. The Medical Director established a protocol to ensure that when the quality of an imaging study is compromised, the technician will immediately inform the ordering physician for further evaluation and management.</p> <p>o. Training has been developed and a schedule established to educate DCS staff on expectations and implementation of self-administration of medication.</p> <p>p. An audit tool has been established for nursing staff to assess the implementation of self-administration of medication.</p>	<p>8/09/13</p> <p>8/31/13</p> <p>8/01/13</p> <p>8/23/13</p> <p>8/23/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
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(W 104)	Continued From page 16 using on Sunday 7/28/2013. Outside shed 2 doors broken and on the ground on 7/29/2013. A rusted 2 seat bicycle was observed in this shed with many cobwebs. It appeared in disrepair. An old shower chair was observed in the back yard. The US stated that he did not know how long it had been there. PESTS: 25. Observation on 7/29/2013 at approximately 10:00 revealed the following: Outside shed with dirty blankets on the ground and a lot of rodent debris. US stated that all of the droppings were rabbit droppings or squirrel. The US stated that he did not report these rodent droppings to maintenance and did not report them for the pest control exterminator. The US stated that he cleaned up the animal droppings himself before any pest control or exterminator representative could inspect and accurately or positively identify the animal droppings. None of the above findings were recorded in the maintenance log book. Cleanliness and Infection Control 26. The food and beverage refrigerator located in the locked staff lounge, Room 9, was overcrowded and soiled with food spills at 2:23 pm on 7/30/2013. The RN was observed placed the individual client's 2:00 pm snacks in this refrigerator on 8/8/2013. Three cut, unwrapped, unlabeled and undated tuna fish sandwiches were described by the Registered Nurse, RN, as "sick." The RN stated that she was not going to dispose of them and would not throw them away as she did not know who they belonged to. Written menu review revealed Tuna sandwiches were listed on the 8/5/2013 menu as the evening snack for all facility residences.	(W 104)	q. Facility rounds conducted by Governing Body/Program Management/Unit Supervisor/IPC's were revised to include assessment, intervention, and documentation of injuries per facility protocol. W102 In addition to the system-wide plans that have been implemented by the Governing Body, staff training has been developed and completed on the following topics: • FDC Policy 5.1 Clinical Standards of Care (Skin Integrity) • FDC 5.4.2 Change of Condition • FDC 5.5.5 General Event Reporting (reporting/documenting Minor Unknown Injuries) • FDC Policy 5.5.5 Attachment A - Types of Incidents (Falls) • NP 10.02 Helmet Usage • NP 10.06 Neuro Checks • NP 11.01 Temporary Conditions • NP 11.02 Client Injury Assessment and Intervention • NP 11.04 Daily Care Flow Sheets/Daily Care Flow Sheet Form • Problem/Temporary Condition/Temporary Support Plan Log • Physical Observation and Documentation Checklist • Change In Usual Self/Behavior Document • HRC Review of Law Enforcement Intervention • Dignity in Care • Respectful Interaction • Professional Boundaries • Behavior Support Positive Practices • SPT Rounds Expectations • Autism Training for IPCs and Psychologists Regulatory Requirements and Expectations for QMRP (IPC) (H&W)	8/15/13	

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{W 104}	Continued From page 17 Staff stated that each evening, after dinner, client snacks are placed in this refrigerator mixed in with all the staff food. Observation on 7/29/2013 at approximately 10:30 revealed the following: Soiled cover with gross spillage on clean laundry cart. Dirty men's T-shirt mixed in with clean towels in Room 63. Hair brush (no name) unlabeled on the floor in Room 63. Noise Level 27. Surveyor heard a loud telephone ring on 8/5/2013 at 3:00 pm. Interview with the direct support staff stated that the telephone must be at a high (loud) volume so staff can hear it when working with individual clients in the Group Rooms. The Residence psychologist was interviewed at 4:00 p.m. The Residence psychologist stated that she had brought her concern about the loud telephone ring to the FDC management and the Program Director. She was concerned about the loud noise for the 7 individuals on sleeping medications for insomnia and the individuals with autism. Management told the Residence psychologist that nothing could be done about the loud noise of the Residence. 30 telephone ringing	{W 104}	<ul style="list-style-type: none"> Regulatory Expectations and Role of the Psychologist (H&W) Interdisciplinary Team Process (H&W) Residents' Handbook and Residence House Rules. <p>Follow-up/review for staff knowledge and awareness of the standards will be incorporated into focus calendars for review at huddle/shift change meetings.</p> <p>W 104, A</p> <ul style="list-style-type: none"> a. FDC 5.5.5 Attachment A -- Types of Incidents was revised to add falls/suspected falls (with or without injury) as an event that requires initiation of a General Event Report (GER). b. Training related to FDC 5.5.5 Attachment A -- Types of Incidents was provided to DCS. c. Facility Policy 5.5.5 Attachment I -- Guidelines for Completing Level I and II Review was revised to include information specific to investigating fall/suspected falls. d. A template was developed to prompt Level I reviewers (supervisors) with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions. e. NP 11.01 Temporary Conditions and NP 11.02 Client Injury Assessment and Intervention were developed to prompt DCS to identify and report injuries or other changes in condition immediately. f. Training related to NP 11.01 Temporary Conditions and NP 11.02 Client Injury Assessment and Intervention was provided to DCS. g. The AE revised the General Event Reporting Tracking Log to include the event time in order to more accurately monitor that the 24 hour requirement for reporting to CDPH is consistently met. 	9/09/13 8/30/13 9/09/13 9/09/13 9/09/13 8/09/13 9/09/13 8/12/13	

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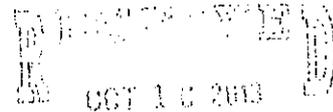
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{W 104}	Continued From page 18 team discussed that [REDACTED] [REDACTED] Sampled Client 151 [REDACTED] The Unit Supervisor, US verified that there was no system to address maintenance issues on 7/29/2013. On 7/29/2013 the US had no work orders that had been submitted on Resident 30 since 6/17/2013. At this time, the US stated he could phone in repair requests when needed. Residence 28 28. On 7/30/13, at 6:30 a.m., on Residence 28 during an observation of morning activities, the phone located in the nurses' station rang. The phone was attached to a bell in the hall. When the phone rang a loud ring could be heard throughout the residence A unit supervisor was present. He was asked if the phone could be heard in the residents' rooms. He stated, "I never checked it but I am sure I could hear it in the rooms." On 8//13 at 10:30 a.m., an interview was conducted with the unit manager. The unit manager agreed the phone was too loud and the clients could hear it ring while in their rooms. An observation was made of the clients' rooms located near the nurses' station. The wall had an opening at the top that would allow the ringing to	{W 104}	h. An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body developed improvement plans for addressing identified issues. i. The Program Risk Management Review (PRMR) meeting process has been fully implemented and has incorporated attendance by the Agency Evaluation Risk Manager/designee. This meeting includes a close review of OPS reports/ investigations and/or other investigative reports, review of client injuries or other changes in condition, restrictive interventions utilized, cumulative data related to GERs, and other health and safety concerns. Improvement plans are established by Program Management to ensure clients are free from harm and that individual rights and freedoms are in place. j. The revised process for Case Disposition has been fully implemented to ensure thoroughness of investigations. k. The newly developed process for administrative investigation has been fully implemented to provide a mechanism for further investigation of events after the GER has been completed and the OPS investigation presented at Case Review. W104, B a. Facility Admission Policy 1.9.1 Admission/Readmission was revised to address admission requirements. b. A screening tool was developed to assess clients for appropriate admission to FDC and to screen clients already admitted to FDC for their continued appropriateness.	8/09/13 7/01/13 7/01/13 7/01/13 9/09/13 8/15/13	

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(W 104) (W 111)	Continued From page 19 be easily heard. 483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and maintain a record keeping system that 1. documented Client 63's active treatment, when multiple pages on "Independent Life Skills Assessment (ILSA)" forms lacked client identifier information. This failure meant that the pages submitted for review might have actually belonged to another client therefore may have contained erroneous information relative to the client for which the information was requested; 2. failed to document a client's change of condition [REDACTED] (Client 198); and 3. failed to ensure that [REDACTED] client 162 contained the correct client name. Findings: Residence-44 (Client 63) 1. On 8/7/13, review of an [REDACTED] submitted for review on Client 63 showed that in the lower right hand corner where there was an area designated for client identifying information, multiple pages of the document submitted for review lacked the client's	(W 104) (W 111)	c. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. d. The IDT will assess appropriateness of current placement and make immediate adjustments to ensure the safety of others. The IDT will review and modify current behavioral support plan as indicated to ensure protection of others and reintegrate the individual into the most appropriate living environment. W104, C a. The current protocol for reporting the need for repairs on the residences/off-site training areas was revised to ensure better communication between residences and Plant Operations and to ensure that repairs are completed in a timely manner. b. FDC is in the process of purchasing a software program that will streamline the process for logging work orders. c. Plant Operations has recently hired additional staff to assist with building maintenance and repair. d. A process was developed for partnership between the Energy Resource Specialist I and the General Services Administrator to conduct weekly maintenance environmental inspections. e. A QAPI will be developed to monitor environmental and maintenance service. W104, Item 1 a. Facility Policy 5.5.5 Attachment I - Guidelines for Completing Level I and II Review was revised to include information specific to investigating fall/suspected falls.	9/09/13 9/09/13 9/09/13 9/09/13 8/30/13	



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(W 111)	<p>Continued From page 20.</p> <p>name, facility number, and name of the residence on which the client resided. Although some pages did document Client 63's name, many of the pages had no identifying information whatsoever. 18 of the 21 pages provided contained no client name, residence number or client facility number to definitively ensure that the information being reviewed was specific to this client.</p> <p>Residence 28 - Client 198</p> <p>2. Client 198 was observed on residence 207 on 8/7/13 at 4:00 p.m. Client 198 [REDACTED] but was ambulatory and able to answer yes/no questions.</p> <p>The clinical record for Client 198 documented that the client [REDACTED] was receiving eye drops daily.</p> <p>During an interview on 8/6/13 at 3:15 p.m., social services staff stated that she observed redness and swelling of the client's right eye on 7/3/13 and reported it to residence staff.</p> <p>During an interview on 8/7/13 at 3:15 p.m., the registered nurse stated that on 7/9/13 (six days later) she was on the client's residence when licensed staff reported that Client 198's eye was red and swollen. She observed that the client's right eye was bulging, swollen, and red.</p> <p>During an interview on 8/7/13 at 2:50 p.m., licensed staff responsible for administering eye drops to Client 198 stated that the client's eye was red in the morning of 7/3/13, the eye drops improved the redness slightly, then the redness</p>	(W 111)	<p>b. A template was developed to prompt Level I reviewers (supervisors) with questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions.</p> <p>c. An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body developed improvement plans for addressing identified issues and will monitor action plans through Agency Evaluation meetings.</p> <p>d. The Program Risk Management Review (PRMR) meeting process has been fully implemented and has incorporated attendance by the Agency Evaluation Risk Manager/designee and IPC. This meeting includes a close review of OPS reports/ investigations and/or other investigative reports, review of client injuries or other changes in condition, restrictive interventions utilized, cumulative data related to GERs, and other health and safety concerns. Improvement plans are established by Program Management to ensure clients are free from harm and that individual rights and freedoms are in place.</p> <p>e. The revised process for Case Disposition has been fully implemented to ensure thoroughness of investigations.</p> <p>f. The newly developed process for administrative investigation has been fully implemented to provide a mechanism for further investigation of events after the GER has been completed and the OPS investigation presented at Case Review.</p>	9/09/13 8/09/13 7/01/13 7/01/13 7/01/13	

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{W 111}	Continued From page 21 was present again by noon. She stated a note would be documented in the Interdisciplinary Notes (IDNs) every shift. If the client had a health condition which required following. During concurrent review of the clinical record with the registered nurse who observed the client on 7/9/13, there was no documentation of the condition of the client's right eye between 7/3/13 and 7/9/13 in the IDNs or anywhere else in the record. There was no documentation in the IDNs about the client's condition for 12 hours following the note by the registered nurse. There was no documentation that the physician had been notified of the condition of the client's eye until 7/9/13. Client 198's health care plan P6-14, initiated 5/30/13, specified that staff were to "Document observations and report them as clinically indicated" every shift. The facility's policy for Documentation Guidelines required that changes in condition were to be assessed and documented, including a full set of vital signs, objective and subjective data, and notification of the attending physician promptly. Residence 30 Client 162 3. Record review on 8/1/2013 revealed Client 162's clinical record was not accurate. Two incorrect names were list for Client 162's IPP. Client 162's vocational assessment dated 7/10/2013 included the typed name: [REDACTED] is not Client 162's Name. When asked, Administrative Staff state these incorrect names were typing errors.	{W 111}	g. The Program Risk Manager will monitor each GER during the Level II Review to ensure that Level I guidelines are followed and that a thorough investigation has been completed. h. Agency Evaluation Director/designee will monitor each GER during the Level III Review to ensure that Level I and II guidelines are followed and that a thorough investigation has been completed. i. The Governing Body will review GERs during daily debriefing meetings and make recommendations for additional administrative investigation as indicated. W104, Item 2 a. Facility Admission Policy 1.9.1 Admission/Readmission was revised to address admission requirements. b. A Screening Tool was developed to assess clients for appropriate admission to FDC and to screen clients already admitted to FDC for their continued appropriateness. c. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. As identified, the IDT will make immediate adjustments to ensure the safety of others. The IDT will review and modify behavioral support plans as indicated, and assess the individual's living arrangement to determine placement in the most appropriate setting. d. A schedule has been developed to reassess all clients on Res. 343 and 344 for appropriate placement in their current living environment. e. Client 77 was administratively transferred to [REDACTED]. f. Supervision levels for Client 65 was enhanced to [REDACTED]	9/09/13 8/15/13 9/09/13 8/15/13 8/09/13 8/12/13	
W 120	483.410(d)(3) SERVICES PROVIDED WITH	W 120			

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W 120	<p>Continued From page 22 OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and facility document review, the facility failed to assure that Office of Protective Services officers met the needs of Client 114 when he was handcuffed on the facility campus.</p> <p>Findings:</p> <p>Residence 28-- Client 114</p> <p>On 7/12/13, Client 114 was seen by staff on his residence at 7:50 p.m. At 8:00 p.m., staff was unable to locate the client, who had walked out an unlocked door. Two Office of Protective Services officers (OPS) found the client on campus and offered him a ride. The GER documented that the client "became resistive and started to run into the street." The street was the on-campus street with a speed limit posted as 25 miles per hour.</p> <p>The General Event Report (GER), documented that Client 114 was returned to the residence 20 minutes after first being noticed as missing, having been handcuffed by OPS. When questioned upon his return to the residence, the client stated "[Client's first name] Walking."</p> <p>During an interview on 8/8/13 at 7:35 a.m., residence licensed staff stated that Client 114 would go walking on campus with his family members who visited regularly.</p>	W 120	<p>g. [REDACTED] The IDT is conducting weekly reviews of his Active Treatment program and the continued need for enhanced supports.</p> <p>h. [REDACTED] Evaluation was completed and the IDT agreed to modify, [REDACTED] regime.</p> <p>[REDACTED]</p> <p>j. Training was initiated with DCS on modifications to Client 65's IPP, following each change.</p> <p>k. The Executive, Clinical and Program Director will monitor clients for behavioral trends and will make adjustments to living situations as indicated to provide a safe environment and protect other clients from harm.</p> <p>W 104 Item 3-15</p> <ul style="list-style-type: none"> • FDC is in the process of purchasing a software program that will streamline the process for logging work orders. • Plant Operations initiated the hiring process for additional staff to assist with building maintenance and repair. • The current protocol for reporting the need for repairs on the residences/off-site training areas was revised to ensure better communication between residences and Plant Operations and to ensure that repairs are completed in a timely manner. • A process was developed for partnership between the Energy Resource Specialist I and the General Services Administrator to conduct weekly maintenance environmental inspections. 	8/12/13	8/15/13
				9/01/13	
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REGISTRATION
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W 120	Continued From page 23 Client 114 was observed on 8/8/13 between 7:36 a.m. and 8:05 a.m. actively walking around the day room on his residence. He would occasionally sit in a chair for a brief time then purposefully and repetitively walk around the room. During an interview on 8/8/13 at 9:00 a.m., residence administrative staff stated that Client 114 was very comfortable walking on campus. He stated that the client may flail his arms which looks like fighting but is not. He stated Client 114 was not a confrontational person and was having no behavioral issues when he left the residence on 7/12/13. He stated the expectation would be for OPS to locate a client who is AWOL, keep him safe, then call the residence and wait for staff to arrive. He further stated, "OPS may have produced" the behavior. Facility policy and procedure (P&P) 6.9, Campus Safety and Security - Office of Protective Service (OPS) Police, documented the responsibilities of Police Officers Included, "Assist in locating clients on unauthorized absences." The P&P further specified that "clinical staff responsible for the client... will make every reasonable and appropriate attempt to control the client's behavior without the use of any protective equipment." Facility administrative staff identified OPS as not part of the facility. There was no documentation in the GER that residence clinical staff responsible for the client had been notified by OPS prior to the client being handcuffed or that OPS waited for clinical staff to arrive.	W 120	<ul style="list-style-type: none"> • A QAPI was developed to monitor environmental and maintenance service.* <p>W104, Item 3</p> <ul style="list-style-type: none"> a. Work order to repair the sink coverings was sent to Plant Operations. b. Unit Supervisor provided training to DCS on environmental expectations. c. Shift Lead/Designee will inspect bathroom each shift during environmental rounds to ensure they are in good repair. If anything needs repair or replacement, they will initiate work order/replacement process. d. The Shift Lead/Designee will monitor during daily environmental rounds to ensure that work orders are submitted for environmental issues. e. The Unit Supervisor/Designee will monitor work orders for timely completion of maintenance issues and follow-up as indicated. f. The Energy Resource Specialist I/Designee will conduct weekly inspections for repairs and review pending maintenance issues for completion and will report findings to ASD for resolution. <p>W104, Item 4</p> <ul style="list-style-type: none"> a. Staff immediately replaced all missing toilet rod holders and all toilets checked. b. Housekeeping staff performed deep cleaning to Bathroom 264 to eliminate urine odor. c. Shift Lead/Designee will inspect bathrooms each shift during environmental rounds to ensure they are in good repair, have toilet paper rods and no odor. If anything needs repair or replacement, they will initiate work order/replacement process. If odors are noted, housekeeping will be contacted for cleaning. 	10/10/13 8/21/13 9/09/13 7/29/13 7/29/13
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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626	
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{W 122}	<p>Continued From page 25</p> <p>Based observations, interviews, record and document reviews, the facility failed to ensure the Condition of Participation, Client Protections, was met. Individuals were subjected to physical, verbal and /or psychological harm and the facility did not take steps to prevent reoccurrence or implement their policies and procedures.</p> <p>Allegations of mistreatment, neglect or abuse as well as injurious of unknown source were not reported immediately, complete and through investigations were not conducted with appropriate corrective actions to prevent re-occurrences as defined by policy and in compliance with federal regulations were not taken. Individuals were subjected to the use of physical restraints and individual freedoms were denied or restricted without consent or justification.</p> <p>Individuals rights were not promoted; to wear appropriate clothing, attend social and religious activities, ensure privacy during treatment and care of personal needs.</p> <p>The Individual Program Coordinator did not ensure active treatment programs were implemented, coordinated and monitored. Staffing and training was not provided in accordance with clients' needs and communications from family were not promptly returned.</p> <p>The survey team met with the Acting Executive Director, the Acting Clinical Director, and the Director of Agency Evaluation on 8/8/13 at 4:05 p.m. and two separate incidents of IMMEDIATE JEOPARDY.</p>	{W 122}	<p>b. Unit Supervisor assigned DCS a specific caseload to ensure client bedrooms and living areas are organized, in good repair and personalized.</p> <p>c. Unit Supervisor will train DCS on caseload responsibilities and expectations.</p> <p>d. Shift Lead/Designee will monitor during daily rounds to ensure client bedrooms are clean, organized and in good repair and that DCS meet the caseload responsibilities assigned to them.</p> <p>W104, #9</p> <p>a. Unit Supervisor moved the refrigerator to a working outlet and all refrigerators were checked.</p> <p>b. Unit Supervisor initiated a work order to repair the non-functioning outlet.</p> <p>c. Shift Lead/Designee will check the refrigerator to ensure it is working during daily environmental shift rounds and follow work order procedures as indicated.</p> <p>W104, #10</p> <p>a. Broken planter was immediately removed from the backyard on</p> <p>b. Unit Supervisor provided training to DCS on environmental guidelines and expectations.</p> <p>c. Shift Lead/Designee will ensure the backyard is clean and safe during daily shift environmental rounds. If something is broken or in disrepair, he/she will discard it immediately or initiate work order process.</p> <p>W104, #11</p> <p>a. The client bedroom was restructured to ensure unimpeded access to the bathroom.</p> <p>b. Unit Supervisor completed environmental rounds to ensure there were no other areas that had a partially blocked passage into another room/bathroom.</p>	<p>9/09/13</p> <p>7/29/13</p> <p>7/31/13</p> <p>7/31/13</p> <p>9/09/13</p> <p>7/31/13</p> <p>7/31/13</p>

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{W 122}	<p>Continued From page 26</p> <p>On 8/9/13 at 1:35 p.m. the survey team accepted the facility's corrective action plan for both incidents of IMMEDIATE JEOPARDY. After review of evidence of implementation of the corrective action plan, the survey team abated the first incident of IMMEDIATE JEOPARDY on 8/9/13 at 1:35 p.m. with the Acting Executive Director, Acting Clinical Director, and the Director of Agency Evaluation. (See W127)</p> <p>On 8/16/13 at 3:35 p.m., after review of evidence of implementation of the corrective action plan for the second incident, the survey team abated IMMEDIATE JEOPARDY on 8/16/13 at 3:35 p.m. with the Acting Executive Director, the Director of Agency Evaluation, and the Standards Compliance Coordinator. (See W149).</p> <p>The facilities failures are evidenced by the following:</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure consents were obtained before restricting access to the environment and telephone usage on Residences 23, 28 and 30. (See W124) 2. The facility failed to teach and encourage individual clients to exercise their rights to access their environment on Residence 23, 28, 41, and 44 and usage of the telephone on Residence 41. This affected all clients residing on Residences 23, 28, 41 and 44. (See W125) 3. The facility failed to ensure that clients and staff were not subjected to physical, verbal, and psychological abuse. A client, with a history of aggression and ongoing threats of harm and 	{W 122}	<p>c. Shift Lead/Designee will conduct rounds to ensure that entrances and exits are not blocked.</p> <p>W104, #12</p> <ol style="list-style-type: none"> a. The Refrigerator was cleaned and all expired items were removed. b. PA scheduled training for DCS on Dietary Policy "Food Storage Rotation and Shelf Life" guidelines. c. The instructor/teachers will complete daily rounds which will include checking the refrigerators. d. The PA/designee will conduct weekly rounds in the classroom worksites to ensure refrigerators are clean and food items are stored according to guidelines. <p>W104, #13</p> <ol style="list-style-type: none"> a. The patio and surrounding areas of Goodell School were assessed and cleaned of debris and cigarette butts were removed. b. The CPS PD/designee will monitor the patio for safety issues and will contact Plant Operations for assistance and follow up as indicated. c. The Energy Resource Specialist I / Designee will conduct weekly inspections for repairs and review pending maintenance issues for completion and will report findings to ASD for resolution. <p>W104, #14</p> <ol style="list-style-type: none"> a. The Shift Lead contacted the work order desk on 7/29/13 to report that the door on Room 50 on Residence 43 was difficult to open due to just being painted the day prior. b. Plant Operation responded and completed repairs on the door. c. The Shift Lead/Designee will monitor during daily rounds to ensure that work orders are completed for environmental issues and document in the Maintenance Log. 	7/29/13 9/09/13 7/29/13 9/09/13 7/29/13 7/30/13	

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{W 122}	Continued From page 27 Intimidation, did not receive effective interventions to ameliorate the immediacy of serious threats to clients/staff. After engaging in a significant assault with great bodily injury to a peer and spending approximately two and one half weeks in prison, the client continued to reside on Unit 44 and continued to aggress on peers and staff resulting in physical intimidation, verbal threats, and actual harm. Individuals expressed fear and felt unsafe in their own living environment. (See W127) 4. The facility failed to ensure that two clients (Client 184 and Client 178) were free from physical restraints and provided active treatment to reduce the dependency. This failure resulted in Client 178 sustaining an injury to her face and Client 184 kept in a restraint for longer than the prescribed length of time. (See W128) 5. The facility failed to ensure Clients 85 and 113 opportunity for personal privacy. (See W129) 6. The facility failed to ensure privacy during treatment and care of personal needs for Clients 1, 130, and 188. (See W130) 7. The facility failed to ensure one of 20 core sampled clients (Client 90) had the opportunity to attend social religious activities and Clients 171 and 184 had not attended off campus activities or on campus special events since February 2013 (six months). (See W136) 8. The facility failed to ensure Clients 76, 107 and all clients residing on Residences 29 and 31 were assisted to retain and use personal possessions. Client bedrooms failed to contain any personal	{W 122}	d. The US/Designee will monitor the Maintenance Log for timely completion of maintenance issues and follow-up as indicated. e. The Energy Resource Specialist I/Designee will conduct weekly inspections for repairs and review pending maintenance issues for completion and will report findings to ASD for resolution. W104, #15 a. The Shift Lead removed the debris from the water fountain and then cleaned it on b. The Shift Lead removed all paper debris from the patio area. c. The Shift Lead/Designee will monitor during daily rounds to ensure that the patio is free of debris, the water fountain is clean and in good working order. d. The US/Designee will monitor during rounds to ensure the patio area is clean and free from debris, including the water fountain. W104, #16 a. Shift Lead immediately placed the items in the refrigerator. b. The client refrigerator was defrosted and will be checked daily by the Shift Lead to ensure it is in working condition. c. The US provided training to DCS on Nursing Procedure 5.04 "Supplements". d. The PD provided training to Shift Leads on Environmental Guidelines initiated. e. The US/Designee will monitor during rounds to ensure the environment is clean, equipment is in working order, and food items are stored appropriately.	7/29/13 7/29/13 7/30/13 7/30/13 9/09/13 9/09/13	

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{W 122} Continued From page 28
decorative possessions, nor displayed anything of their individuality, preferences, or experiences. (See W137)

9. The facility failed to ensure that one un-sampled client (Client 76) was ensured the right to be dressed in the client's personal clothing each day. This failure resulted in the Client 76 being dressed in other clients' clothing as well as dirty and sometimes ill fitting clothing which at times interfered with the client's daily activities. (See W138)

10. The facility failed to promptly answer communications with Client 90's family member concerning opportunity for attendance at social religious activities. (See W144)

11. The facility failed to ensure that staff followed policy and procedures for 1 of 20 sampled clients, Client 12, for promptly identifying bruises of undetermined origin and injuries of unknown origin; for ensuring that a protective helmet was free of defects and for ensuring that there was documented treatment for a witnessed fall. The collective cluster of these events (within a month) and the staffs' negligence, impacted the health, safety and welfare of the client with resultant bodily harm. Client 12 was admitted to an outside acute care hospital with a bruise on the neck, a rib fracture of unknown length of time, a hematoma (blood clot) under the scalp, paralysis of the lower extremities and a fracture of the cervical (neck) spine. Client 12 underwent surgery for the cervical fracture and is now a quadriplegia (paralysis of arms and legs) and has a tracheostomy opening into the trachea with oxygen administration. (See W149)

{W 122} W104, #17
a. A work order was initiated to adjust the locking mechanism to provide for the safety of the client. 8/21/13
b. DTAC Coordinator trained classroom staff on Client 184's Approaches and Strategies, Risk Assessment Summary and documentation expectations regarding safety awareness. 8/21/13
c. Day training staff received training on "Professional Boundaries" regarding appropriate intervention. 8/07/13
d. Day training staff received training on "Dignity In Care" regarding appropriate intervention. 9/06/13
e. Day training staff received training on "Behavior Support Positive Practices" regarding appropriate intervention. 9/03/13
f. Day training staff received training on "Respectful Interactions" regarding appropriate intervention. 9/06/13
g. The DTAC Coordinator/designee will ensure that the door mechanism is working correctly during rounds.
h. The facility Rounds Team will observe staff interactions during rounds provide coaching to staff as needed. Results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.

W104, #18
a. The US completed a work order request to have light in bathroom #68 adjusted for increased lighting. 7/30/13
b. The facility Electrician adjusted the sensor to increase lighting in bathroom #68. 8/07/13
c. US checked all other bathrooms on residence to ensure that the sensor allowed the light to remain on for an adequate amount of time with no further issues noted. 7/30/13
d. US on Res. 31 provided training to DCS on process for requesting work order/repairs. 9/09/13

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{W 122}	Continued From page 29 12. The facility failed to ensure that staff did not verbally abuse clients, when a Licensed Staff used harsh and loud commands during her interactions with clients, and further displayed disrespect when speaking about them as if children and in front of them. This objectifying attitude demonstrated by a staff towards dependent adults had the potential to result in further abuse and mistreatment when neither co-workers nor supervisors noted the staff interactions as abusive. (See W150) 13. The facility failed to report all allegations of mistreatment, neglect or abuse as well as injurious of unknown source immediately to the administrator and the Department within twenty four hours and the facility failed to ensure that injuries of unknown origin were identified and reported immediately to the administrator, and that the policy and procedure for reporting such injuries was in compliance with federal regulations and implemented. This failure affected un-sampled Clients 61, 64, 76, 78, 121, 180, 193, and potentially all individuals receiving care and services at the facility. (See W153). 14. The facility failed to implement policy number 5-05-5 titled "General Event Reporting" and "Guidelines for Completing Level I and II Review" of the GER dated 6/13/13 and ensure timely, complete and thorough investigations were done for all alleged violations of individual rights. This directly affected one of 20 core sampled clients and 12 un-sampled clients. Clients 3, 10, 12, 17, 34, 45, 48, 50, 60, 61, 63, 71, 74, 76, 81, 114 and potentially all clients residing at the facility. (See W154)	{W 122}	W104, #18 e. The US/designee will monitor during rounds to ensure that lights on the residence are functional providing adequate lighting. W104, #19 a. Facility Policy 5.5.5 Attachment A – Types of Incidents was revised to add falls/suspected fall (with or without injury) as an event that requires initiation of a General Event Report (GER). b. Facility Policy 5.5.5 Attachment A – Types of Incidents was reviewed by the Governing Body and it was determined that the definition of injuries of unknown origin is consistent with CMS regulations CFR483.420(d)(2). c. Nursing Procedure 11.01 Temporary Conditions and Nursing Procedure 11.02 Client Injury Assessment and Intervention were developed to prompt DCS to identify and report injuries or other changes in condition immediately. d. Facility Policy 5.1.1 Clinical Standards of Care was revised to include a section on assessing skin integrity during client care. e. DCS received training in FDC 5.1.1 Clinical Standards of Care. f. A Problem/Temporary Condition/ Temporary Support Plan Log was developed and implemented to ensure DCS communicate and display continuity in documentation of identified health issues/injuries. g. DCS received training regarding the Problem/Temporary Condition/ Temporary Support Plan Log. h. Nursing Procedure 11.04 Daily Care Flow Sheets was developed and implemented, along with Daily Care Flow Sheets to provide a more efficient tracking mechanism for DCS to document important ADL services/supports throughout the client's day.	8/30/13 8/09/13 8/30/13 9/09/13 8/15/13 8/15/13 8/19/13	

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{W 122}	Continued From page 30 15. The facility failed to take corrective actions when Client 65 physically assaulted one peer twice and three other peers on the residence in a ten week period. This placed all clients on the residence at risk for psychological and physical harm. (Un-sampled Clients' 65, 72, 75 and 82) (See W157)	{W 122}	i. DCS received training in NP11.04 Daily Care Flow Sheets and the implementation of and expectations of documenting on the Daily Care Flow Sheets.	9/09/13	
	The cumulative effect of these systemic problems resulted in the developmental center's inability to ensure that specific client protections requirements were met.		j. A Physical Observation and Documentation Checklist was developed to assist DCS in assessing, notifying appropriate people, and documenting injuries.	8/15/13	
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	{W 124}	k. A Change In Usual Self/Behavior document was developed and distributed to residence staff to assist DCS staff to capably assess individuals on an ongoing basis. The document was reviewed at daily change-of-shift huddles.	8/15/13	
	This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the rights of clients when informed consents were not obtained for restricted access to the clients' living areas on Residences 23, 28, and 30 and when access to food, recreational items, and areas of the home were restricted on Residence 30. These restrictions had the potential to affect 58 clients living in these residences.		l. A Quality Assurance Performance Improvement (QAPI) log was established to monitor DCS adherence to assessment and documentation protocols.	8/01/13	
	Findings: Residence 23		m. DCS received training on FDC 5.4.2 Change of Condition.	9/09/13	
			n. DCS received training on FDC 5.5.5 General Event Reporting -Minor Unknown Injury reporting.	9/09/13	
			o. Rounds conducted by the Rounds Team (Governing Body/Program Management/US/Shift Lead/IPC's) were revised to include assessment, intervention, and documentation of injuries per facility protocol.	8/09/13	
			p. Results of Facility rounds were tabulated and will be presented to the Governing Body via AE meeting. Program Management will develop and implement improvement plans where concerns are noted.	9/09/13	
			q. Program Management/US/Shift Leads will monitor for injuries and other change in condition during rounds and provide coaching as indicated.		
			r. The Rounds Team will monitor for injuries and other change in condition during rounds and provide coaching as indicated.		

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{W 124}	<p>Continued From page 31</p> <p>1. The following observations were made on Residence 23 on 7/29/13 at 9:45 a.m.: access to the kitchen was locked, both tub rooms were locked, and the client's phone was located in the locked nursing station.</p> <p>On 7/30/13 at 9:15 a.m., access to the kitchen was locked, both tub rooms were locked and the clients phone was located in the locked nursing station.</p> <p>An interview was conducted with the unit supervisor on 7/31/13 at 9:00 a.m. The unit supervisor stated the clients' phone had been moved from behind the locked nurses' station and was now readily available to clients.</p> <p>Client 87 and Client 90's record was reviewed. There was no informed consent for restricted access.</p> <p>Residence 28</p> <p>2. The following observations were noted on Residence 28 on 7/29/13 at 10:30 a.m.: one tub room was locked and the doors to the kitchen was locked.</p> <p>On 7/30/13 at 6:30 a.m., the phone room was locked and access to the kitchen was locked.</p> <p>On 7/30/13 at 8:45 a.m., an interview was conducted with the unit supervisor. He stated night shift staff locked the kitchen.</p> <p>On 7/31/13 at 9:00 a.m., the residence manger stated the phone room, tub rooms, and the kitchens were to remain unlocked at all times.</p>	{W 124}	<p>s. Round results will be calculated, analyzed by the AE Staff Services Analyst and presented to the Agency Evaluation Committee members for follow-up action plans as indicated.</p> <p>W104, #20</p> <p>a. Unit Supervisor initiated training for Residence 30 Staff on Facility Policy 6.6.18 "Personnel Services: Attendance and Staffing Guidelines".</p> <p>b. Unit Supervisor met with Shift Leads and clarified expectations that daily assignment sheets are to be completed at the start of each shift and staff informed of their assignment including rest and meal periods on AM and PM shifts.</p> <p>c. Unit Supervisor will monitor sign-in and staff assignment sheets to ensure staff are signing in and Shift Leads are maintaining daily assignment sheets including rest and meal periods.</p> <p>d. Staff sign-in sheets will be monitored at the daily Program Management debrief meeting (on regular work days)</p> <p>W104, #21</p> <p>a. Work Order submitted and doors repaired in Residence 30 Room. 25 and 36.</p> <p>b. US re-trained the Acting US/SPT on Work Order System</p> <p>c. Program Director provided training to Shift Leads on Environmental Guidelines</p> <p>d. The US/Designee will monitor during rounds to ensure the environment is clean, equipment is in working order, and food items appropriately stored.</p> <p>e. The Energy Resource Specialist I/GSA will conduct weekly maintenance and environmental inspections and report findings to ASD for resolution.</p>	9/09/13	9/09/13
				7/29/13	9/09/13
				9/07/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626	
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{W 124}	Continued From page 32 During a review of Client 105 and 107's charts, there were no informed consents for restricted access. Residence 30 Locked Client's Snacks and Food: 3. During observation on 7/29/13 at 10:00 a.m., the refrigerator at Residence 30 was observed in a room behind a locked door. This door was labeled "Staff Lounge." When staff opened the door, it required the use of a key. No Residence 30 individual's had a key to unlock this door. During the two week survey, the US, the RN and other direct support staff stated that this was the only refrigerator on Residence 30 for both staff and individual's food. During the survey individual's 2:00 pm and 8:00 pm Dietary snacks were placed in this client inaccessible refrigerator. (Refer to W.104, W454) Locked Doors: 4. Observations on 7/29/13 at 10:00 a.m., revealed a locked conference room, locked visitors room, locked activity room, locked arts and crafts in room 66, locked tub room, individual bedroom doors to the outside locked and room 24 locked. The US stated that families could visit individuals in the locked conference room. But, only staff had a key to unlock this door. Throughout the survey, the room labeled, visitor's room, was locked. The US stated that he	{W 124}	W104, #22 a. Work Order submitted, recorded in log book and repairs to dresser on Res 30 Room. 55 completed. b. US re-trained the Acting US/SPT on Work Order System 9/09/13 c. PD provided training to Shift Leads on Environmental Guidelines. d. The US/Designee will monitor during rounds to ensure the environment is clean, equipment is in working order, and food items appropriately stored. e. The Energy Resource Specialist I/GSA will conduct weekly maintenance and environmental inspections and report findings to ASD for resolution. W104, #23 a. Work order submitted and recorded in log book for repairs to drinking fountain Res 30 Rooms, 27 and 37. b. PA followed up with Engineer regarding repairs of drinking fountains Res 30 Rooms, 27 and 37. Replacement drinking fountains have been ordered. c. US re-trained the Acting US/SPT on the Work Order process System. d. PD provided training to Shift Leads on Environmental Guidelines. e. The US/Designee will monitor during rounds to ensure the environment is clean, equipment is in working order, and food items appropriately stored. f. The Energy Resource Specialist I/GSA will conduct weekly maintenance and environmental inspections and report findings to ASD for resolution.	7/29/13 9/09/13 9/07/13 7/29/13 9/09/13 9/09/13 9/07/13

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{W 124}	<p>Continued From page 33</p> <p>was using the labeled visitor's room as his office for the previous 2 weeks when he was appointed Acting US. The office appeared cluttered and not usable as a visitor's room.</p> <p>During the survey, three different families were observed attempting to visit Residence 30. One family was observed waiting outside the locked front door ringing the doorbell. This family member told the surveyor that no staff would answer the door bell so left the area. The family told the surveyor she planned to telephone the residence since she could not gain entrance, through the locked front door, to visit her brother.</p> <p>Activity staff stated that the music room is kept locked because there are confidential Client Records kept in this room. Also staff stated that individual client's money is locked in a drawer in the music room. Also some clients have PICA behavior and it is unsafe to have this room unlocked.</p> <p>Record Review revealed the signed consent forms for Client 150, 151 and 162 contained no information which addressed locked conference room, locked visitors room, locked music room, locked Room 24 containing labeled individual's coats, hats and shoes and other personal belongings, locked individual's 2:00 pm and 8:00 pm beverages and snacks from the dietary department, or the locked activity room with recreational items.</p> <p>Client 150 was observing walking unaccompanied and independently to her Work Activity Center, WAC, on 8/1/2013 at 9:00 am. When Client 150 arrived at the WAC Room 36 at 9:08 am Room 36 was locked. Client 150 was</p>	{W 124}	<p>W104, #24</p> <p>a. Res 30 Lattice removed from fencing</p> <p>b. Res 30 Drinking fountain on patio was cleaned.</p> <p>c. PA initiated training for US and Shift Supervisor on Res 30 "Environmental Guidelines for ICF Programs"</p> <p>d. Drinking glasses and pitcher on Res 30 returned to the kitchen for cleaning</p> <p>e. Property movement form completed to remove shed from yard and all furniture/other items that are not used and/or are in disrepair.</p> <p>f. Rusted bicycle and old shower chair on Res 30 removed from the yard.</p> <p>g. US re-trained the Acting US/SPT on Work Order System</p> <p>h. The US/Designee will monitor during rounds to ensure the environment is clean, equipment is in working order, and food service items appropriately stored.</p> <p>W104, #25</p> <p>a. Blankets identified on Residence 30 was removed</p> <p>b. The US restated expectation to DCS on removing articles from yard after use</p> <p>c. US initiated training for Residence 430 staff on Facility Policy 6.11.6 "Housekeeping, Janitorial/Waste Disposal and Pest Control Services"</p> <p>d. US re-trained the Acting US/SPT on Work Order System</p> <p>e. PD provided training to Shift Leads on Environmental Guidelines.</p> <p>f. The US/Designee will monitor during rounds to ensure the environment is clean, equipment is in working order, and food items appropriately stored.</p>	<p>7/29/13</p> <p>7/29/13</p> <p>9/07/13</p> <p>7/29/13</p> <p>9/09/13</p> <p>7/29/13</p> <p>9/07/13</p> <p>7/29/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/07/13</p>

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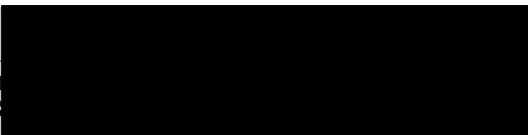
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{W 124}	Continued From page 34 observed waiting outside alone until 9:15 am before any staff came to unlock the door. The staff member told the surveyor that there was no permanent instructor for this room and that she was at a mandatory 8:30 am meeting and could not arrive at the shredding work room during the time Client 150 was waiting. Staff went on to state that Client has campus access to and from work and no history of AWOL. Record review revealed no signed consent for Client 150's Work Activity Center, WAC, and Room 36 to be locked when she arrives for work on a work day. Client 150 was observed waiting outside alone until 9:15 am before any staff came to unlock the door. The staff member told the surveyor that there was no permanent instructor for this room and that she was at a mandatory 8:30 am meeting and could not arrive at the shredding work room during the time Client 150 was waiting. Staff went on to state that Client has campus access to and from work and no history of AWOL. The outside bedroom door for Client 151 was locked. The bedroom door required the use of a metal key, not a card key. Record Review revealed no signed informed consent form for the outside bedroom door for Client 151 which was locked during all observations beginning on 7/29/13 at 9:30 a.m. Staff stated this door is always locked and never used to access the outside. Client 151's IPP read Individual client lives on unlocked Unit. The fact that the front and back doors were key card access was not recorded in	{W 124}	W104, #26 a. Housekeeper cleaned the staff refrigerator on Residence 30. b. Client food was removed from staff refrigerator and discarded. c. A sign was posted on the staff refrigerator on Residence 430 indicating that "no client food is to be stored in staff refrigerator and that all food must be clearly labeled with dates". d. The Unit Supervisor developed a schedule for DCS to monitor and clean refrigerator(s) once per week or as needed including discarding any unlabeled food. e. Unit Supervisor initiated training for Res. 30 staff on Nursing Procedure 5.04 "Food Supplements" f. Unit Supervisor initiated training for Res. 430 staff on storage of snack and supplements g. Program Assistant initiated training for Unit Supervisors and Shift Supervisors on "Fairview Developmental Center Environmental Guidelines for ICF Programs" h. The Unit Supervisor/designee will monitor refrigerators during rounds to ensure they are clean and that client and staff food are stored separately. W104, #27 a. Facility Electrician lowered the Residence 30 phone ringer volume. b. Facility purchased additional cordless phone handsets. A schedule has been established for installation on Residence 30. c. A signal expander has been ordered to ensure the phone can be utilized throughout Residence 30. d. A plan was developed to ensure phones are not attached to a loud bell	7/30/13 7/30/13 7/30/13 7/30/13 8/21/13 9/09/13 9/07/13 8/21/13 9/09/13 9/09/13 9/09/13		

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(W 124)	Continued From page 35 the IPP.  At the time of the survey, Client 151, Client 150 and Client 162 and twenty-four other men and women lived at Residence 30. During observations at Residence 30 beginning at 9:30 AM on 7/29/13, and during all subsequent observations conducted throughout the survey, the outside front and back doors were locked requiring a card key. Other bedroom doors leading to the outside were locked. These doors required the use of a metal key, not a card key. Locked Bathtub Area: 5. The door to the only Bathtub Area in Residence 30 was locked and required the use of a key to unlock the door. During observations conducted with the Unit Supervisor on 7/29/13 beginning at 9:30 AM, the Unit Supervisor unlocked the door and explained that that one of the bathtubs was going to be removed and taken out of Residence 30. The Unit Supervisor confirmed that none of the clients who lived at Residence 30 had a key which would unlock the door to the bathtub. These Client's Informed Consents did not address the locked door to the bathtub. When asked Administrative staff confirmed the locking of these doors was not based on	(W 124)	W104, #28 a. Facility Electrician lowered the Residence 28 phone ringer volume. b. Facility purchased additional cordless phone handsets. A schedule has been established for installation on Residence 28. c. A signal expander has been ordered to ensure the phone can be utilized throughout 28. d. A plan was developed to ensure phones are not attached to a loud bell W111, #1 a. ILSA for Client 63 was immediately corrected and replaced. b. Clinical Records staff will monitor documents to ensure they meet documentation standards prior to filing in the Clinical Record. W111, #2 a. US provided training to DCS on Client 198's Health Care Plans, including documentation expectations b. US on Res 28 provided training to DCS on Facility Procedure 05.04.02 "Change in Condition" c. US on Res 28 provided training to DCS on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention". d. US on Res 28 provided training to DCS on expectation that health care plans for any client returning from Acute Hospitalization (in the community or at the facility) will be reviewed by all pertinent staff (including but not limited to Medication Nurse and Health Services Specialist) upon readmission to home residence. e. US, SPT and IPC on Res 28 will randomly monitor IDNs and MARs for documentation of temporary conditions and provide follow up as indicated.	9/09/13 9/09/13 9/09/13 9/09/13 8/07/13 8/15/13 8/21/13 8/09/13 9/09/13	

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{W 124}	Continued From page 36 Individual assessed needs of the clients living at Residence 30, no informed consent, no access training plans in place, and no Human Rights Committee Review and Approval. The Individual Program Coordinator (IPC), who serves as the Qualified Intellectual Disabilities Professional for Client 150, Client 151, and Client 162 was interviewed at 8:30 AM on 8/8/13. When asked the IPC did not confirm the teams for Client 150, Client 151 and Client 162 had not assured that all rights restrictions had been identified and discussed for these sampled clients. The IPC confirmed that the teams for Client 150, 151 and 162 had not considered the need for consent from the clients' legally sanctioned decision maker for these restrictions.	{W 124}	W111, #2 f. Program Director/designee will review 24 hour report and NOD Report daily for client conditions to ensure that changes are being monitored per protocol. g. Changes in client condition for Residence 28 will be reviewed, discussed and action plans implemented as indicated at Management Debrief Meetings held daily (on regular work days).		
{W 125}	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to teach and encourage individual clients to exercise their rights to access their environment on Residences 23, 28, 30, 41, 42 and 44 and useage of the telephone on Residences 30 and 41. This restricted access had the potential to affect 54 clients residing on Residences 23, 28, and 44, 19 clients on Residence 41, 22 clients on Residence 42, and 27 clients on Residence 30.	{W 125}	W111, #3 a. Client 162's Vocational Assessment was corrected by the instructor and submitted to Clinical Records for filing. 8/1/13 b. A protocol was initiated for the Vocational Supervisor to review and approve all vocational assessments prior to submission. c. Supervisor of Vocational Services will monitor Vocational Assessments to ensure that they meet the documentation standards. W120 a. A General Event Report (GER) is initiated and investigated via the Level I and II process for OPS use of law enforcement involvement. b. OPS Officers generate a police report following use of law enforcement involvement that is reviewed and approved by the Commander. c. The Governing Body reviews all instances of Law Enforcement Involvement (LEI) with the Commander/designee and makes recommendations as indicated. d. The HRC Committee criteria for reviewing LEI was revised to be more inclusive of clinical and OPS investigations. e. The Human Rights Committee (HRC) Manual was revised to include the role of OPS during Behavior Emergencies..	8/01/13 9/01/13	9/09/13 9/09/13

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{W 125}	Continued From page 37 Findings: Residence 41 1. During environmental observations of the residence on 7/29/13 at 9:40 a.m., with the Licensed Staff member, five (5) shower chairs in client bathroom 56 were lined up against the wall blocking the door of 1 of 2 toilet stalls, thereby restricting access. During an interview with the Licensed Staff member at that time, she stated that the shower chairs were usually stored in a room in a bathroom that is currently down for maintenance. 2. During environmental observations of the residence on 7/29/13 at 10:10 a.m., with the Licensed Staff member, a room that she stated was the client telephone room did not have a telephone. Licensed Staff stated that the telephone was brought into the room during telephone hours approximately 8:15 a.m. to 9:15 a.m., 4 p.m. to 5 p.m. and 8 p.m. to 9 p.m. This practice restricted clients' telephone access to only specified, set times. 3. During environmental observations of the residence with the Licensed Staff member on 7/29/13 at 10:05 a.m., a door located outside the residence in the patio area was locked. When the Licensed Staff member unlocked the door, there was a large box filled with varying sizes of balls, several lawn activity supplies and 2 large cutting shears.	{W 125}	W120 f. A collaborative workgroup consisting of representatives from OPS, Governing Body, Managerial, and Clinical areas was formed to discuss delineation of clinical and police responsibilities during behavioral events that endanger self or others. g. A template was developed to prompt Level I reviewers with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions. h. Approaches & Strategies for Client 114 was updated to alert staff that [REDACTED] i. Shift Lead/designee on Residence 428 will monitor throughout the shift to ensure that the environment is safe and secure. W 122, #1 a. Governing Body members are working with H&W Consultants to review access and informed consent processes to ensure that individual rights and freedoms are protected. b. The Access Support Consent process was revised to include the access support training plan in the consent packet. c. A schedule was developed to review individual clients access needs, initiate a new informed consent as indicated, and develop plans that promote individual freedoms and rights as indicated. d. US on Residence 23 unlocked the tub room, phone room and kitchen hallway door. e. Lock removed from the phone room on the identified Residence. f. DCS on Residence 423, 428, and 430 were reminded at change of shift huddle that kitchen, tub rooms and phone room are to be accessible to clients based on individual access assessment.	9/09/13 9/9/13 7/13/13 9/09/13 9/09/13 9/09/13 7/29/13 8/12/13 7/29/13

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{W 125}	Continued From page 38 During an interview with the Licensed Staff at that time, she stated that the door was probably locked for safety, because the shears were stored inside. Residence 42 4. During environmental observations on the residence with the Acting Unit Supervisor (AUS) on 7/29/13 at 10:50 a.m., the client group room, located near the movie room, had an interior door which was locked. When the AUS unlocked the door, there was a large supply of client activity items. The AUS stated that the door is locked because some of the clients have PICA (ingesting inedible items) behavior. He further stated that the staff "puts out" what supplies the clients' needs. This practice restricted clients access to activities items in the room. Residence 44 5. During tour of the facility on 7/31/13 at approximately 9:30 a.m., the Unit Supervisor (US) unlocked a locked tub room door (Bathroom 220) with a key and entered. Within was a bathtub. In reference to the locked door the US stated "It's because of the supervision level." The US stated that because most clients needed supervision when bathing due to seizures and other needs, that this bathtub was restricted to use by clients, rather a second tub room down the hall was utilized for client bathing and was kept unlocked and accessible. The bathtub was observed to be wet with a wet washcloth and when asked about the reason for this, the US stated it probably had been recently cleaned by housekeeping.	{W 125}	g. PA/Designee on 23 trained Shift Leads on "Environmental Guidelines for ICF Programs" which includes the expectation that client living areas are unlocked and well organized. h. Consent and approval was obtained for Client 105. [REDACTED] [REDACTED] Shift Lead provided training to DCS regarding training plan. 8/29/13 [REDACTED] [REDACTED] [REDACTED] for Client 107 has been scheduled to be reviewed/approved by Human Rights Committee. l. Individual access was reviewed with DCS as part of the focus calendar. m. The Rounds Team will monitor to ensure that client areas are accessible and well organized. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. W122, #2 a. Active Treatment Coordinators have been designated on each Program and are responsible for the development and implementation of Active Treatment projects to be integrated facility-wide, with emphasis on promoting choices and independence in all environments. b. Clients on Residences 23, 28, 41, 44 have the ability to utilize the telephone at all times. c. Shift Leads on Residence 28 provided training to DCS on client rights regarding phone usage. d. US/designee on 28 will make rounds to ensure the phone is available and DCS are encouraging clients to exercise their right to utilize the phone.	9/07/13 8/29/13 7/10/13 7/10/13 9/09/13 8/13/13 9/09/13 8/1/13

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(W 125)	Continued From page 39 On 7/31/13 at 10:15 a.m., a housekeeping staff stated the bathtub had not been cleaned during the morning since there had been a client in the tub taking a bath with a staff person also present in the room. 6. The following observations were made on Residence 23 on 7/29/13 at 9:45 a.m.; access to the kitchen was locked, both tub rooms were locked, and the clients' phone was located in the locked nursing station. On 7/30/13 9:15 a.m., access to the kitchen was locked, both tub rooms were locked and the clients' phone was located in the locked nursing station. An interview was conducted with the Unit Supervisor on 7/31/13 at 9:00 a.m. The Unit Supervisor stated the clients' phone had been moved from behind the locked nurses' station and was now readily available to clients. Residence 28 7. The following observations were noted on Residence 28 on 7/29/13 at 10:30 a.m.; one tub room was locked and the access to the kitchen was locked. On 7/30/13 at 6:30 a.m., the phone room was locked and access to the kitchen was locked. On 7/30/13 at 6:45 a.m., an interview was conducted with the Unit Supervisor. He stated night shift staff locked the kitchen. On 7/31/13 at 9:00 a.m., the Residence Manager stated the phone room, tub rooms, and the	(W 125)	W122, #3 a. Facility Admission Policy 1.9.1 Admission/Readmission was revised to address admission requirements. b. A Screening Tool was developed to assess clients for appropriate admission to FDC and to screen clients already admitted to FDC for their continued appropriateness. c. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. d. Client 77 was assessed for appropriateness of placement and immediate adjustments were made to ensure the safety of others. e. Client 77 was administratively transferred to another developmental center. f. Clients on Residence 344 were assessed with the updated screening tool for appropriateness of current placement forwarded to Program Management for follow up as indicated. g. Executive Director, Clinical Director and Program Director will monitor clients for behavioral trends and will make adjustments to living situations as indicated to provide a safe environment and protect other clients from harm. W122, #4 a. A Special Conference for Client 184 was held [REDACTED] Client 184's program plan was revised [REDACTED] b. A Follow-up meeting was scheduled to review Client 184's progress in 30 days c. [REDACTED] Milestone [REDACTED] was developed for Client 184.	9/9/13 8/15/13 9/09/13 8/08/13 8/09/13 9/09/13 8/12/13 9/09/13 8/13/13	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 125}	Continued From page 40 kitchens were to remain unlocked at all times. On 8/1/13 at 1 p.m., a review of clients' access to snacks was conducted with the Residence Manager in the dining room. The Residence Manager noted the refrigerator located in the clients dining room area. The refrigerator contained brown lunch bag type bags with clients' names on them. He explained that some of the clients were assigned snacks, but not all of the clients. He agreed not all clients had access to snacks. Residence 30 8. The following sign was posted on the wall outside the telephone room. It read: " Patient Phone Hours 8-9 am, 11:30-1:00 pm, 3:30-8:00 p.m. An additional sign was posted on the wall which read: "It's almost 9:00 make your last call." A unsampled client, Client 159 was observed during the survey utilizing this telephone to make personal calls. Inside the telephone room there was a sign- in sheet with this individual's had written signatures written indicating when she had used the telephone. Client 162 was assessed on 8/25/12 as sometimes able to use the telephone to make and receive calls. When asked on 8/5/2013, direct support staff indicated that these telephone hours were current and staff enforced these hours with the individuals. When the surveyor asked about the Saturday, Sunday and holiday hours, the staff replied the telephone hours are no different when the clients have a day off and are home from	{W 125}	W122, #4  e. The US/designee trained Res. 31 DCS on Section IV of "Protecting Human Rights" manual and Facility Policy 05.04.04 "Protective Devices" with emphasis on justification expectations and identifying criteria to discontinue use of restrictive interventions. f. The US on Residence 31 initiated a schedule to review restrictive protective documentation to ensure rationale remains current and plan to discontinue criteria is justified. k. US/SPT/IPC on Residence 31 will monitor changes in condition or lack of progress at Emerging Risk Review. g. The expectation for IPC site visits was revised to include follow-up visits to any program area where a client is not making progress or is experiencing difficulty. h. IPC will monitor implementation of  milestone and will document progress in the monthly note. Any concerns will be discussed with US for resolution. i. IPCs received training on the following topics: Autism, Regulatory Requirements for QMRP (IPC), IDT process. W122, #5 a. New facility policies 5.3.1 Behavior Support Principles (and Glossary), 5.3.2 Behavior Support Programs and 5.3.3 Behavior Techniques and Interventions were developed and distributed. Policy 5.3.3 specifically addresses the expectation for applying restraints in a manner that protects clients' privacy and dignity.	8/16/13 8/14/13 9/09/13 9/01/13 9/01/13 9/06/13 8/30/13

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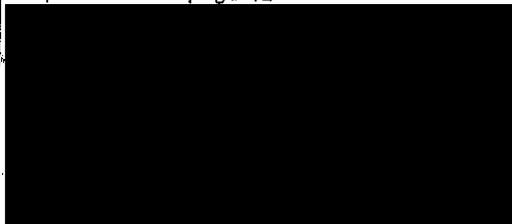
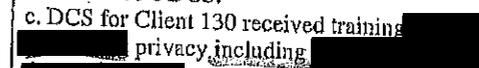
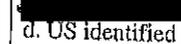
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{W 125}	Continued From page 41 work and day programs on weekends. 9. On 7/31/13 Client 150 was observing walking to her Work Activity Center, WAC, on at 9:00 am. When Client 150 arrived at the WAC Room 36 at 9:08 am Room 36 was locked. Client 150 was observed waiting outside alone until 9:15 am before any staff came to unlock the door. The staff member told the surveyor that there was no permanent instructor for this room and that she was at a mandatory 8:30 am meeting and could not arrive at the shredding work room during the time Client 150 was waiting. Staff went on to state that Client has campus access to and from work and no history of AWOL. On 8/5/13, at 1:00 again Client 150 was again observed standing in the hall outside the locked door to the WAC room 36. When asked, staff verified that the outside door to this room is always kept locked so that no one can enter due to confidential papers. Client 150 September 2009 Vocational Assessment reads: "attends the Newspaper Workshop Mon-Friday mornings 9:00 - 12:00 and Mon-Fri afternoons 1:00-3:00 pm." It is her job to collect her own paper supplies inside the classroom, sort paper by color, and take the tub of paper to the scale for weighting. Client 150: "is able to do all of these tasks independently." When Client Record review revealed Client 150 had a consent signed 12/4/12 for key use system for independent egress during not less than specified hours Dawn to Dusk [REDACTED]	{W 125}	W122, #5 b. A summary of new and key items from those policies were distributed to DCS emphasizing positive behavioral approaches; c. Staff Development provided "Dignity In Care" training to all Residence 28 DCS. d. Acting US/SPT provided "Privacy" training to all Residence 28 DCS. 8/19/13 e. US provided training to DCS on Client 85's residence on FDC 1.3.1 "Mission and Values" with emphasis on their responsibility to ensure clients are provided dignity, respect and quality of life services/treatment. f. US provided training to DCS on Client 85's residence on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination. g. Interdisciplinary team for Client 85 was held to review and modify the behavioral support plan to clearly outline the appropriate location to apply and utilize highly restrictive interventions. Initiated on 8/12/13 h. Unit Supervisor provided training to DCS on the modifications to Client 85's plan. i. US/designee on Residence 44 will ensure program plans are implemented as written during daily rounds. j. Follow-up/review for staff knowledge and awareness of the standards will be incorporated into focus calendars for review at huddle/shift change meetings. k. US/designee will monitor to ensure privacy and dignity are maintained when an individual requires restrictive intervention.	9/09/13 8/28/13 8/19/13 9/09/13 9/09/13 8/12/13 8/15/13	

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{W 125}	Continued From page 42  On 7/31/13 Client 150 was observing walking to her Work Activity Center, WAC, on at 9:00 am. When Client 150 arrived at the WAC Room 36 at 9:08 am Room 36 was locked. Client 150 was observed waiting outside alone until 9:15 am before any staff came to unlock the door. The staff member told the surveyor that there was no permanent instructor for this room and licensed staff was "floated" from Program 4. This acting instructor stated she was from Residence 28. Locked Client's Snacks and Food: 10. During observation on 7/29/13 at 10:00 a.m., the refrigerator at Residence 30 was observed in a room behind a locked door. This door was labeled "Staff Lounge." When staff opened the door, it required the use of a key. No Residence 30 Individual's had a key to unlock this door. During the two week survey, the US, the RN and other direct support staff stated that this was the only refrigerator on Residence 30 for both staff and individual's food. During the survey individual's 2:00 pm and 8:00 pm Dietary snacks were placed in this client inaccessible refrigerator. (Refer to W.104, W454) Locked Doors: 11. Observations on 7/29/13 at 10:00 a.m.,	{W 125}	W122, #6 a. Training was initiated for DCS on "Dignity In Care". b. "Privacy" training was provided to Client 188 and 130's DCS. c. DCS for Client 130 received training  privacy including  d. US identified gender specific restrooms on Residence 431. e. "Female" and "Male" signs were installed on designated bathroom doors on Residence 431. f. Residence 431 DCS received training on gender specific restrooms. g. Residence 431 DCS oriented clients to the gender specific restrooms. h. Residence 431 grooming supplies relocated to the correct gender specific restrooms. i. Unit Supervisor provided training to DCS on Client 1's residence on FDC 1.3.1 "Mission and Values" with emphasis on their responsibility to ensure clients are provided dignity, respect and quality of life services/treatment. j. Unit Supervisor provided training to DCS on Client 1's residence on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination. k. Training was provided to Residence 41 DCS on FDC Policies 5.1.2 Continuous Active Treatment, 5.1.1 Standards of Care, 1.1.5 Clients' Rights, NP 5.5.1 Gastrostomy Tube Feeding.	8/28/13 8/19/13 9/9/13 8/15/13 8/22/13 8/15/13 8/15/13 9/09/13 9/09/13 9/09/13	

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{W 125}	<p>Continued From page 43</p> <p>revealed a locked conference room, locked visitors room, locked activity room, locked arts and crafts in room 66, locked tub room, individual bedroom doors to the outside, locked and room 24 locked.</p> <p>The US stated that families could visit individuals in the locked conference room. But, only staff had a key to unlock this door.</p> <p>Throughout the survey, the room labeled, visitor's room, was locked. The US stated that he was using the labeled visitor's room as his office for the previous 2 weeks when he was appointed Acting US. The office appeared cluttered and not usable as a visitor's room.</p> <p>Activity staff stated that the music room is kept locked because there are confidential Client Records kept in this room. Also staff stated that individual client's money is locked in a drawer in the music room. Also some clients have PICA behavior and it is unsafe to have this room unlocked.</p> <p>Record Review revealed the signed consent forms for Client 150, 151 and 162 contained no information which addressed locked conference room, locked visitors room, locked music room, locked Room 24 containing labeled individual's coats, hats and shoes and other personal belongings, locked individual's 2:00 pm and 8:00 pm beverages and snacks from the dietary department, or the locked activity room with recreational items.</p> <p>Client 150 was observing walking unaccompanied and independently to her Work Activity Center, WAC, on 8/1/2013 at 9:00 am.</p>	{W 125}	<p>l. Rounds team (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure privacy and dignity are maintained during ADLs. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.</p> <p>m. Follow-up/review for staff knowledge and awareness of the standards will be incorporated into focus calendars for review at huddle/shift change meetings.</p> <p>W122, #7</p> <p>a. A new protocol was developed and implemented to address expectations related to quantity and quality of community outings. 9/09/13</p> <p>b. Active Treatment Coordinators have been designated on each program and are responsible for the development and implementation of active treatment projects to be integrated facility-wide, with emphasis on promoting choice and independence in all environments. 9/09/13</p> <p>c. Rehabilitation Therapist conducted an audit of Activity Records and provided training to DCS on Client 171 and 184's residence on documentation. 9/9/13</p> <p>d. US will monitor to ensure that all clients are provided regular opportunities to participate in community activities.</p> <p>e. Unit Supervisor provided training to DCS for Client 90 on expectations. 8/23/13.</p> <p>f. DCS ensured Client 90 was afforded the opportunity and documented his. 8/23/13</p> <p>g. US/designee reviewed documentation to ensure the opportunity was provided. 8/23/13</p>	

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{W 125}	Continued From page 44 When Client 150 arrived at the WAC Room 36 at 9:08 am Room 36 was locked. Client 150 was observed waiting outside alone until 9:15 am before any staff came to unlock the door. The staff member told the surveyor that there was no permanent instructor for this room and that she was at a mandatory 8:30 am meeting and could not arrive at the shredding work room during the time Client 150 was waiting. Staff went on to state that Client has campus access to and from work and no history of AWOL. Record review revealed no signed consent for Client 150's Work Activity Center, WAC, and Room 36 to be locked when she arrives for work on a work day. Client 150 was observed waiting outside alone until 9:15 am before any staff came to unlock the door. The staff member told the surveyor that there was no permanent instructor for this room and that she was at a mandatory 8:30 am meeting and could not arrive at the shredding work room during the time Client 150 was waiting. Staff went on to state that Client has campus access to and from work and no history of AWOL. The outside bedroom door for Client 151 was locked. The bedroom door required the use of a metal key, not a card key. Record Review revealed no signed informed consent form for the outside bedroom door for Client 151 which was locked during all observations beginning on 7/29/13 at 9:30 a.m. Staff stated this door is always locked and never used to access the outside. Client 151's IPP read individual client lives on	{W 125}	h. Since client was transitioning into the community the new care providers were informed of family preferences. i. A QAPI was developed to monitor community outings. The report information is reviewed by the Governing Body and improvement plans are initiated. W122 #8 a. Social Workers contacted the families of the individuals residing on Res. 28, 29, 30, and 31, including Client 107, requesting family photos and other personal items to decorate client bedrooms and living areas. b. US reviewed expectations with DCS that clients be assisted to obtain personal possessions which emphasize individuality and personal preferences. c. Bedroom for Client 107 is in the process of being redecorated to reflect his individuality and preferences. d. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will monitor client living areas to ensure living areas reflect personal preferences, interests and likes during observations. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. e. US developed a Daily Clothing Inventory List for Client 76 to ensure that he has sufficient clothing in his wardrobe cabinet at all times. f. US/Designee provided training to DCS on the Daily Clothing Inventory List for Client 76. g. US assigned each DCS a caseload that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing. h. US/Designee trained DCS on the expectations of their client caseloads.	8/29/13 7/01/13 9/3/13 9/9/13 9/09/13 9/9/13 9/9/13 9/9/13
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{W 125}	<p>Continued From page 45</p> <p>unlocked Unit. The fact that the front and back doors were key card access was not recorded in the IPP.</p> <p>Client 162's IPP dated 8/16/12 read: "Currently lies on an unlocked residence." Client 162 [REDACTED]</p> <p>At the time of the survey, Client 151, Client 150 and Client 162 and twenty-four other men and women lived at Residence 30. During observations at Residence 30 beginning at 9:30 AM on 7/29/13, and during all subsequent observations conducted throughout the survey, the outside front and back doors were locked requiring a card key.</p> <p>Other bedroom doors leading to the outside were locked. These doors required the use of a metal key, not a card key.</p> <p>Locked Bathtub Area:</p> <p>12. The door to the only Bathtub Area in Residence 30 was locked and required the use of a key to unlock the door. During observations conducted with the Unit Supervisor on 7/29/13 beginning at 9:30 AM, the Unit Supervisor unlocked the door and explained that that one of the bathtubs was going to be removed and taken out of Residence 30.</p> <p>The Unit Supervisor confirmed that none of the clients who lived at Residence 30 had a key which would unlock the door to the bathtub. These Client's Informed Consents did not address the locked door to the bathtub.</p>	{W 125}	<p>i. US/Shift Lead/Designee will ensure client clothing is well fitted and clean during daily rounds and will set expectations and coach staff when they see ill-fitting or unclean clothing on clients and that DCS order and maintain clothing for their caseload assignment.</p> <p>W122 #9</p> <p>a. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly</p> <p>b. US developed a Daily Clothing Inventory List for Client 76 to ensure that he has sufficient clothing in his wardrobe cabinet at all times.</p> <p>c. US/Designee provided training to DCS on the Daily Clothing Inventory List for Client 76.</p> <p>d. US assigned each DCS a caseload that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing.</p> <p>e. US/Designee trained DCS on the expectations of their client caseloads.</p> <p>f. US/Shift Lead /Designee will ensure client clothing is well fitted and clean during daily rounds and will set expectations and coach staff when they see ill-fitting or unclean clothing on clients.</p>	9/09/13 9/09/13 9/09/13 9/09/13	

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{W 125}	Continued From page 46 When asked Administrative staff confirmed the locking of these doors was not based on individual assessed needs of the clients living at Residence 30, no informed consent, no access training plans in place, and no Human Rights Committee Review and Approval. The Individual Program Coordinator (IPC), who serves as the Qualified Intellectual Disabilities Professional for Client 150, Client 151, and Client 162 was interviewed at 8:30 AM on 8/8/13. When asked the IPC did not confirm the teams for Client 150, Client 151 and Client 162 had not assured that all rights restrictions had been identified and discussed for these sampled Clients. The IPC confirmed that the teams for Client 150, 151 and 162 had not considered the need for consent from the clients' legally sanctioned decision maker for these restrictions. (Refer to W124)	{W 125}	122 #10. a. A family satisfaction survey was developed and will be available to families on an ongoing basis. The results will be shared with the Governing Body and improvement plans implemented to ensure ongoing communication with families and to ensure their needs and issues are addressed in a timely manner. b. USs provided training to DCS for Client 90 on expectations for church attendance. c. DCS ensured Client 90 was afforded [REDACTED] d. US/designee reviewed documentation to ensure the opportunity was provided.	9/09/13 8/23/13 8/23/13 8/23/13	
{W 126}	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Residence 30 Client 150 Based on observation, interviews and record reviews, the facility failed to ensure that Client 150 managed her financial affairs to the extent of her capabilities.	{W 126}	W122, #11 a. The following facility policies were revised: 5.1.1 Standards of Care (skin integrity), 5.5.5 General Event Reporting Attachment A - Types of Incidents (falls), 5.5.5 General Event Reporting Attachment I - Level I and II Review of GERs. b. A template was developed to prompt Level I reviewers (supervisors) with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions. c. DCS received training on FDC 5.1.1 Clinical Standards of Care and 5.5.5 General Event Reporting - Attachment A Types of Events (falls) d. DCS received training on 10.02 Helmet Usage, 10.06 Neuro Checks, 11.01 Temporary Conditions (new), 11.02 Client Injury Assessment and Intervention (new), 11.04 Daily Care Flow Sheets (new).	8/09/13 9/09/13 8/16/13 9/09/13	

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{W 126}	Continued From page 47 When the surveyor did not observe any money management training, for Client 150 on 7/30/13 the surveyor returned the following week on 8/5/13 and 8/6/13. Staff stated that they were all different staff working at Work Activity Center, WAC, Room 36 on all different days. Staff indicated there were no regular staff assigned to this room during the survey. Staff interview at 2:30 p.m. on 7/30/13 related that there was no regular instructor at Work Activity Center, WAC, Room 36 for the past 3-4 weeks. The float staff instructor from Goodell School was present. When asked when Client 150's money management training would be conducted, she replied that she really did not know. Float staff instructor stated that she thought the money management training was conducted once per week on Fridays. On 8/6/13 at 1:15 p.m., the staff told the surveyor that there was no permanent instructor for this WAC, Room 36 and licensed staff was "floated" from Program 4. This acting instructor stated she was from Residence 28. On 8/6/13 at 1:15 p.m., staff stated different people were working and that he had never seen the coins for Client 150's money management training and did not know where these training materials would be kept. Staff went on to state that the coins may be in the locked office requiring a metal key to unlock the office door. This staff person did not have a key to this office to unlock this door. When the surveyor asked this staff person to explain the data sheet which had recorded "0" the	{W 126}	e. DCS received training on FDC5.4.2 Change of Condition, FDC 5.5.5 General Event Reporting - Minor Unknown Injury reporting, and NP 10.06 Neuro Checks. f. The following Nursing Procedures were developed or revised: 10.02 Helmet Usage, 10.06 Neuro Checks, 10.09 Vital Signs, 11.01 Temporary Conditions (new), 11.02 Client Injury Assessment and Intervention (new), 11.04 Daily Care Flow Sheets (new). g. A Protection From Harm Manual was developed and distributed to all facility staff. The manual contains an overview of Client Protection principles as well as a hierarchy of processes in place to prevent and/or mitigate client risks and serves as a reference for managers/supervisors and DCS. h. A Problem/Temporary Condition/Temporary Support Plan Log was developed and implemented to ensure DCS demonstrate continuity in documentation of identified health issues/injuries. i. DCS received training on the Problem/Temporary Condition/Temporary Support Plan Log. j. A Daily Care Flow Sheet was developed and implemented to provide a more efficient tracking mechanism for DCS to document important ADL services/supports throughout the client's day. k. DCS received training on the Daily Care Flow Sheet. l. A Physical Observation and Documentation Checklist was developed and distributed to residence staff to assist DCS in assessing, notifying appropriate people, and documenting injuries or other changes in condition. m. DCS received training on the Physical Observation and Documentation Checklist.	9/09/13 9/09/13 9/09/13 8/15/13 8/13/13 8/19/13 9/09/13 8/16/13 8/15/13	

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{W-126}	Continued From page 48 staff explained that this must mean that the training was not conducted. Record review revealed Client 150's [REDACTED] The vocational instructor was listed as the provider, the location of the training was WAC room 36; duration of the training BID 1115-1145 and 1500-1530. [REDACTED]	{W 126}	n. A Change In Usual Self/Behavior document was developed and distributed to residence staff to assist DCS in more capably assessing individuals' care on an ongoing basis. o. The IPCs and Health Service Specialists (HSS) were added as participants to daily Program Management Meetings to facilitate identification of and immediately address developing issues and trends for clients in their caseload. p. An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body reviewed the findings and developed improvement plans for addressing identified issues. q. An audit of DCS' adherence to Nursing Procedures 11.01 Temporary Conditions and 11.02 Client Injury Assessment and Intervention was conducted to ensure expectations are being met for assessment and documentation of injuries and other physical conditions. r. A Quality Assurance Performance Improvement (QAPI) log was established to continue monitoring of DCS adherence to assessment and documentation procedures. s. The PM&R Department conducted an audit of medical and behavioral helmets to ensure cleanliness, proper fit, and proper function. t. A Quality Assurance Performance Improvement (QAPI) log was established to continue monitoring of helmets. The Governing Body reviewed the findings and developed improvement plans for addressing identified issues.	8/15/13 8/26/13 8/09/13 8/31/13 8/01/13 8/23/13 8/23/13	
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.	W 127			

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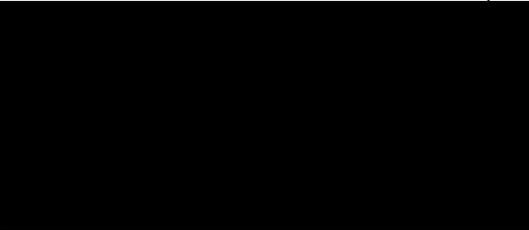
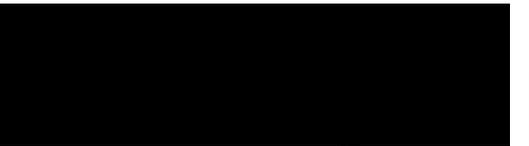
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W 127	<p>Continued From page 49</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, record review, and review of facility documents, the facility failed to ensure that clients and staff were not subjected to physical, verbal, and psychological abuse. Client 77, [REDACTED], did not receive effective interventions to ameliorate the immediacy of serious threats to clients/staff. After engaging in a significant assault with great bodily injury to a client [REDACTED] the client continued to reside on Unit 44 and continued to aggress on peers and staff resulting in physical intimidation, verbal threats, and actual harm. Individuals expressed fear and felt unsafe in their own living environment.</p> <p>The survey team met with the Acting Executive Director, the Acting Clinical Director, and the Director of Agency Evaluation on 8/8/13 at 4:05 p.m. and declared IMMEDIATE JEOPARDY. On 8/9/13 at 1:35 p.m. the survey team accepted the facility's corrective action plan. After review of evidence of implementation of the corrective action plan, the survey team abated the IMMEDIATE JEOPARDY on 8/9/13 at 1:35 p.m. with the Acting Executive Director, Acting Clinical Director, and the Director of Agency Evaluation.</p> <p>Findings: [REDACTED]</p>	W 127	<p>u. The Medical Director established a protocol to ensure that when the quality of an imaging study is compromised, the technician will immediately inform the ordering physician for further evaluation and management.</p> <p>v. The facility Supplemental rounds were revised to include topics specific to client injury assessment, intervention, and documentation.</p> <p>w. An ad hoc committee comprised of medical, health care, clinical and administrative staff was formed to adopt a comprehensive Falls Prevention program. The Fracture/Fall Risk Assessment has been revised to focus on the falls aspect of assessment. It includes a scoring/weight aspect to assist the ID Team in identifying clients at moderate and high risk for falls and care planning accordingly.</p> <p>x. Facility rounds conducted by Governing Body/Program Management/US/IPC's were revised to include assessment, intervention, and documentation of injuries per facility protocol.</p> <p>y. The IPCs and HSS' were added as participants to daily Program Management Meetings to identify and immediately address developing issues and trends for clients in their caseload.</p> <p>z. The Program Risk Manager will monitor each GER during the Level II Review to ensure that Level I guidelines are followed and that a thorough investigation has been completed.</p> <p>aa. Agency Evaluation Director/designee will monitor each GER during the Level III Review to ensure that Level I guidelines are followed and that a thorough investigation has been completed.</p> <p>bb. The Governing Body will review GERs during daily debriefing meetings and make recommendations for additional administrative investigation as indicated.</p>	<p>9/09/13</p> <p>8/15/13</p> <p>9/09/13</p> <p>8/15/13</p> <p>8/26/13</p>	

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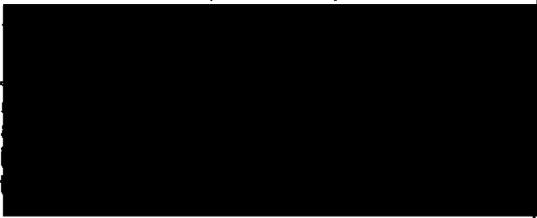
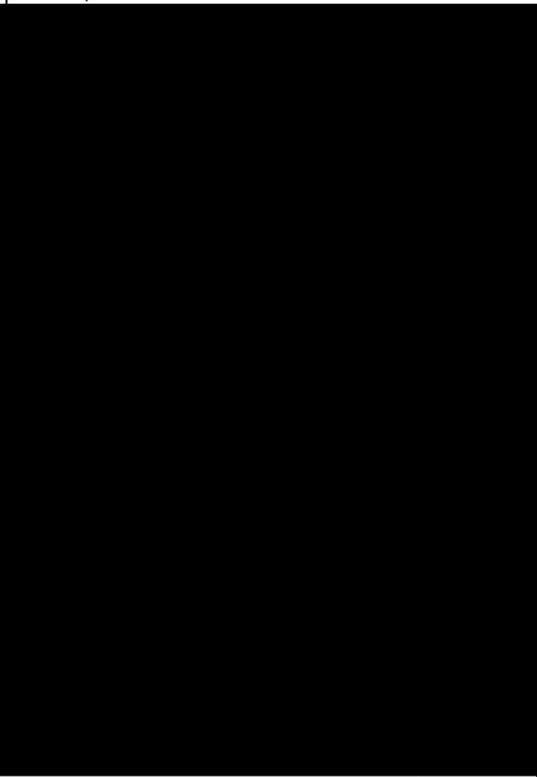
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W 127	Continued From page 50    During an Interview with licensed staff on 8/7/13 at 3:10 p.m., licensed staff stated that Client 77 was presently being provided 2:1 supervision (two clients to one staff) with line of sight supervision while awake. In addition, the "Annual Individual Program Plan Conference," dated 4/4/13, indicated Client 77 was provided 30 minute visual checks while sleeping.  	W-127	W122, #12 a. DCS and IPCS received training on Dignity in Care. b. DCS and IPCS received training in Respectful Interaction. c. DCS and IPCs received training in Professional Boundaries. d. DCS and IPCs received training in Behavior Support Positive Practices. e. Staff involved removed from client contact and corrective action was initiated. f. A new instructor was assigned to classroom 133. g. Rounds Team to monitor during rounds conducted in the classroom and provide coaching related to positive staff/client interactions as indicated. W122 #13. a. The AB Dept. revised the General Event Reporting Tracking Log to include the event time in order to more accurately monitor that the 24 hour requirement for reporting to CDPH is consistently met. b. Facility Policy 5.1.1 Clinical Standards of Care was revised to include a section on assessing skin integrity during client care c. DCS received training in FDC 5.1.1 Clinical Standards of Care. d. Nursing Procedure 11.01 Temporary Conditions and 11.02 Client Injury Assessment and Intervention were developed to set expectations and provide guidance to DCS regarding changes in a client's usual behavior or change in physical condition. e. A Problem/TC/Temporary Support Plan Log was developed and implemented to ensure DCS communicate and display continuity in documentation of identified health issues/injuries.	8/28/13 8/28/13 8/26/13 9/05/13 7/30/13 7/31/13 8/12/13 9/03/13 9/03/13 8/09/13 8/15/13	

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W. 127	Continued From page 51  A review of significant incidents reflected an extensive history and patterns of aggressive behaviors, as follows: 	W 127	f. DCS received training in the Problem/TC/ Temporary Support Plan Log g. Nursing Procedure 11.04 Daily Care Flow Sheets was developed and implemented, along with Daily Care Flow Sheets to provide a more efficient tracking mechanism for DCS to document important ADL services/supports throughout the client's day. h. DCS received training in NP 11.04 Daily Care Flow Sheets and the implementation of and expectations of documenting on the Daily Care Flow Sheets. i. A Physical Observation and Documentation Checklist was developed to assist DCS in assessing, notifying appropriate people, and documenting injuries. j. A Change In Usual Self/Behavior document was developed and distributed to residence staff to assist DCS to capably assess individuals on an ongoing basis. k. A Quality Assurance Performance Improvement (QAPI) log was established to monitor DCS adherence to assessment and documentation protocols. l. An ad hoc committee comprised of medical, health care, clinical and administrative staff was formed to adopt a comprehensive Falls Prevention program. m. The Fracture/Fall Risk Assessment has been revised to focus on the falls aspect of assessment. It includes a scoring/weight aspect to assist the ID Team in identifying clients at moderate and high risk for falls and care planning accordingly. n. DCS received training in FDC5.4.2.Change of Condition, FDC 5.5.5 General Event Reporting --Minor Unknown Injury reporting, and NP 10.06 Neuro-Checks.	8/15/13 8/13/13 9/09/13 8/16/13 8/13/13 8/01/13 9/05/13 9/09/13 8/15/13	

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W 127	Continued From page 52 12/20/12- Client 77 and two peers assaulted Client 48 by kcking and hitting him in the head and body. Per the GER (General Event Report), dated 12/21/12, the victim, Client 48, sustained a nasal fracture, bruising and severe swelling to the left eye with the inability to open his eye, and several superficial facial scratches. [REDACTED] The "Annual Psychological Evaluation and Functional Assessment" indicated that Client 77 [REDACTED] on 1/18/13, was physically intimidating others and demanding privileges he did not earn. [REDACTED]	W 127	W122, #14 a. FDC 5.5.5 Attachment A – Types of Incidents was revised to add falls/suspected fall (with or without injury) as an event that requires initiation of a General Event Report (GER). b. Training related to FDC 5.5.5 Attachment A. – Types of Incidents was provided to DCS. c. Facility Policy 5.5.5 Attachment I – Guidelines for Completing Level I and II Review was revised to include information specific to investigating fall/suspected falls. d. A template was developed to prompt Level I reviewers (supervisors) with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions. e. NP 11.01 Temporary Conditions and NP 11.02 Client Injury Assessment and Intervention were developed to prompt DCS to identify and report injuries or other changes in condition immediately. f. Training related to NP 11.01 Temporary Conditions and NP 11.02 Client Injury Assessment and Intervention was provided to DCS. g. The AE Dept. revised the General Event Reporting Tracking Log to include the event time in order to more accurately monitor that the 24 hour requirement for reporting to CDPH is consistently met. h. An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body developed improvement plans for addressing identified issues.	8/09/13 8/09/13 9/09/13 9/09/13 8/09/13 9/09/13 8/12/13 8/09/13	

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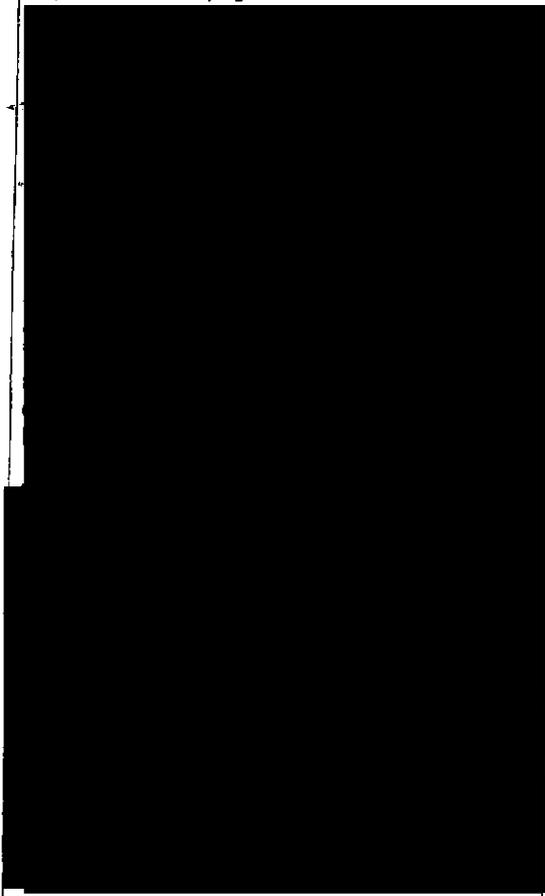
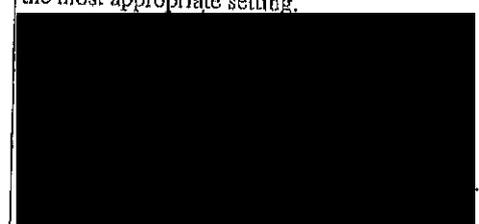
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W 127	Continued From page 53 [REDACTED]	W 127	<p>i. The Program Risk Management Review (PRMR) meeting process has been fully implemented and has incorporated attendance by the AE Risk Manager/designee. This meeting includes a close review of OPS reports/ investigations and/or other investigative reports, review of client injuries or other changes in condition, restrictive interventions utilized, cumulative data related to GERs, and other health and safety concerns. Improvement plans are established by Program Management to ensure clients are free from harm and that individual rights and freedoms are in place.</p> <p>j. The revised process for Case Disposition has been fully implemented to ensure thoroughness of investigations and ensure consistency of facts.</p> <p>k. The newly developed process for administrative investigation has been fully implemented to provide a mechanism for further investigation of events after the GER has been completed and the OPS investigation presented at Case Review.</p> <p>122 # 15.</p> <p>a. A Protection From Harm Manual was developed and distributed to all facility staff. The manual contains an overview of Client Protection principles as well as a hierarchy of processes in place to prevent and/or mitigate client risks and serves as a reference for managers/supervisors and DCS.</p> <p>b. Facility Admission policy 1.9.1 Admission/Readmission was revised to address admission requirements.</p> <p>c. A Screening Tool was developed to assess clients for appropriate admission to FDC and to screen clients already admitted to FDC for their continued appropriateness.</p>	<p>7/01/13</p> <p>7/01/13</p> <p>7/01/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p>	

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W 127	Continued From page 54 	W 127	d. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. As identified, the IDT will make immediate adjustments to ensure the safety of others. The IDT will review and modify behavioral support plans as indicated and assess the individual's living arrangement to determine placement in the most appropriate setting.  g. The Executive, Clinical and Program Director will monitor clients for behavioral trends and will make adjustments to living situations as indicated to provide a safe environment and protect other clients from harm.  j. Training was initiated with DCS on modifications to Client 65's IPP, following each change.	8/12/13 8/12/13 8/15/13 9/09/13	

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W 127	<p>Continued From page 55</p> <p>The psychologist stated that after the arrest, individual and group therapy (anger management) was conducted for the clients involved in the altercation of 12/20/12. The psychologist stated that Client 77 would refuse therapy and intimidate both peers and the psychologist when he tried to break her door down. The psychologist stated, "He became intimidating and very scary."</p> <p>When asked if other clients felt afraid, the psychologist stated, "Yes, they've been intimidated." The psychologist further stated that group attendance went up when Client 77 was no longer part of the group and that Client 77 took advantage of lower functioning individuals and intimidated new staff. The psychologist stated, "He is very dangerous, very unpredictable, and has very little antecedents."</p> <p>Due to the facility's failure to ensure that clients were not subjected to the harm of physical, verbal, and psychological abuse and intimidation, IMMEDIATE JEOPARDY was declared on 8/8/13 at 4:05 p.m.</p> <p>On 8/9/13 at 1:35 p.m., the survey team accepted the facility's corrective action plan. The corrective action plan consisted of the following elements.</p> <ol style="list-style-type: none"> 1. One to one supervision was instituted immediately for the individual identified [Client 77]. Completed 8/8/13. 2. Client 77 was relocated to a separate area [redacted] away from other clients for their protection. Completed 8/8/13. 3. Client 77's location provided him with his own 	W 127	<p>124, #1</p> <ol style="list-style-type: none"> a. Door to hall leading to dining room and Tub room on Residence 23 was unlocked immediately. b. The phone on Residence 23 was relocated to the ledge so the clients would have continual access. c. US/designee will monitor during daily rounds to ensure doors remain unlocked during specified times. d. The US/designee assessed all residences to ensure clients have access to dining room, tub room, and telephone.* e. The "Rounds Team" (Governing Body, Program Management, USs, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to identified areas and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.* f. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* g. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.* 	<p>7/29/13</p> <p>7/29/13</p> <p>8/15/13</p> <p>10/10/13</p>	

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W 127	Continued From page 56 restroom, bedroom, living room, and entrance to the residence. Completed 8/8/13. 4. Staff on Residence 44 were given specific action plan instructions regarding Client 77's expected behavior and programming as well as directions to obtain assistance by activating the Personal Alarm System (including backup system) if he displayed non-compliance with the items listed on the action plan. Completed 8/8/13. 5. Behavior plans and the action plan instructions were reviewed with staff on duty and oncoming shifts. Completed 8/8/13. 6. A plan to relocate the individual for assessment for additional service and support needs was developed in coordination with the Department of Developmental Services, the facility, and [X] Developmental Center. Client 77 will be moved to [X] Developmental Center on 8/9/13. 7. Ongoing assessment and review via the IPP process will be provided to ensure that Client 77's transition and future placements are based on his assessed needs. Completed 8/8/13 and ongoing. 8. Monitoring of ongoing risk data (such as patterns of perpetrator/victim roles in client to client altercations) will be conducted and adjustment of living arrangements will be made, based on acuity needs of individuals. An area on Residence 44 will be available to provide for enhanced services and supports that will allow for the safety of other clients, as well as an identified area for day programming. Individuals will receive services in this area pending reassessment (to include review of placement history, current response to behavioral and	W 127	W 124, # 2. a. US unlocked the tub room, phone room and kitchen on 428. b. Lock was removed from the phone room on 428. c. DCS on 428 were reminded at change of shift huddle that kitchen, tub rooms and phone room are to be accessible to clients based on individual access assessment d. PA/Designee trained Shift Supervisors on "Environmental Guidelines for ICF Programs" which includes the expectation that client living areas are unlocked and well organized. e. Consent and approval were obtained for Client 105 to have supervised access to the tub room and dining room. Shift Lead provided training to DCS regarding training plan. f. Social Worker for Client 107 initiated consent for access based on current ILSA and Special Conference. g. Consent for Client 107 was obtained for limited access to tub room and dining room. h. Access plan for Client 107 has been scheduled to be reviewed/approved by Human Rights Committee. 9/09/13 i. Individual access was reviewed with DCS as part of the focus calendar. 8/13/13 j. The US/designee will ensure that client areas are accessible and well organized during rounds conducted on the residence. k. The USs/designees assessed all residences to ensure clients have access to the tub room, phone room and kitchen.* l. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to identified areas and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*	7/29/13 9/05/13 7/29/13 9/07/13 8/29/13 7/10/13 9/09/13 9/09/13 8/13/13 8/15/13	

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W 127	Continued From page 57 medical support/treatment, and emerging issues) by the ID Team until determination that the individual can be returned to regular program services. Completed 8/8/13.	W 127	m. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* n. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.*	10/01/13	
	9. Standardized admission criteria will be established for assessing clients who are referred to the facility for acute crisis admission. To be completed by 8/15/13.		124, #3. a. Housekeeper cleaned the identified refrigerator on Residence 30. b. Client food was removed from identified refrigerator and discarded. c. Sign posted on identified refrigerator indicating that no client food is to be stored in staff refrigerator and that all food must be clearly labeled.	7/30/13 7/30/13 7/30/13	
W 128	After review of the implementation of the corrective action plan the survey team abated the IMMEDIATE JEOPARDY on 8/9/13 at 1:35 p.m. 483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that two clients (Client 184 and Client 178) were free from physical restraints and provided active treatment to reduce the dependency. This failure resulted in Client 178 sustaining an injury to her face and Client 184 kept in a restraint for longer than the prescribed length of time. Findings: Residence 31	W 128	d. US/designees developed a schedule for Shift Leads to clean refrigerator(s) once per-week including discarding any unlabeled food.* e. US initiated training for Res. 30 staff on Nursing Procedure 5.04 "Food Supplements" f. US initiated training for Res. 430 staff on storage of snack and supplements. g. PA initiated training for Unit Supervisors and Shift Supervisors on "Fairview Developmental Center Environmental Guidelines for ICF Programs" h. The US/Designees will monitor all refrigerators during rounds to ensure they are clean and that client and staff food are stored separately.* i. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) will conduct rounds to ensure appropriate food storage and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*	10/10/13 8/21/13 9/09/13 9/07/13	

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W 128	<p>Continued From page.58</p> <p>1. On 7/30/13 at 9:15 a.m., Client 184 sat in a wheelchair and Licensed Staff secured a seat belt at his waist and then pushed the client in his wheelchair to the client's day program in the Activity Center room 30. Once there, the client sat in the wheelchair, with the seatbelt still fastened and began to hit his hand on a table. After five minutes the Licensed Staff released the seatbelt and the client began to walk about the room. Staff verified that the client was not able to self-release the seatbelt.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>The seatbelt which the client cannot apply or remove, independently, was initiated in March 2013 to decrease attempts to exit the wheelchair during translocation. The IPP indicated that "plans to move to less restrictive will be discussed when [Client 184] has had no injuries from exacerbation of the bursitis for 2 consecutive years. There was no documentation of the date of the last exacerbation.</p> <p>[REDACTED]</p>	W 128	<p>124, # 4.</p> <p>a. Visitor's Room and tub room on 430 were unlocked. 7/29/13</p> <p>b. A Work Order was submitted for signs to be made to correctly identify specified rooms. 9/09/13</p> <p>c. A Work Order was submitted to adjust the volume on the doorbell. 9/09/13</p> <p>d. A Work Order was submitted to have lock on workshop changed. 8/21/13</p> <p>e. The DTAC Coordinator trained DCS on expectation to keep Room 36 unlocked during work hours. 8/23/13</p> <p>f. Vocational Assessment for Client 150 was revised to reflect the current work hours 0915-1200, and 1315-1600 Monday to Friday. 9/6/13</p> <p>g. Vocational Supervisor met with DCS to review the hours of operation in Room 36 and explained the importance of providing access to our clients. 9/9/13</p> <p>h. CPS is developing an Orientation Sheet for float instructors/aids 9/9/13</p> <p>i. Vocational Supervisor/designee will provide orientation to staff who are assigned as a float to the classroom and review class description, class schedule and clients' training plans. 8/6/13</p> <p>j. Vocational Supervisor/designee will conduct rounds to ensure clients have access to entering their work sites during their work schedules. 8/01/13</p> <p>k. An IPP was held for Client 151; the access plan was discussed and related training implemented. 8/01/13</p> <p>l. An IPP was held for Client 162; the access plan was discussed and related training implemented. 9/09/13</p> <p>m. A Special Conference was held for Client 150; the access plan was discussed and related training implemented. 9/09/13</p> <p>n. Governing Body members are working with H&W Consultants to review access and informed consent processes to ensure that individual rights and freedoms are protected. 9/09/13</p>	

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W 128	<p>Continued From page 59</p> <p>On 8/6/13 at 3:45 p.m. Client 184 returned to his residence in his wheelchair with seatbelt accompanied by day program Licensed Staff. At 4:05 p.m., the residence Licensed Staff took the client, still in his wheel chair with seatbelt on, from the backyard to the bathroom. The client remained restrained for twenty minutes after translocation.</p> <p>During a concurrent interview, the residence Licensed Staff stated that she had not observed the client was still restrained until she noticed that he needed to go to the bathroom.</p> <p>2. On 7/30/13 at 7:25 a.m., loud vocalizations were heard coming from Room 11. A random observation revealed, non-sampled Client 178 seated at the end of the bed. Both side rails were up and padded. The client was not able to respond to questions verbally.</p> <p>During an interview on 8/7/13 the Individual Program Coordinator (IPC) stated [REDACTED] that there was a medical order for the restraint. The IPC did not know if less restrictive measure had been attempted such as a low bed and floor mats.</p> <p>Review of a General Event Report (GER) dated 6/21/13 indicated that Client 178 sustained a cut below her left eye which required 3 stitches. Staff assumed that it was due to striking her head on the bed rail padding, which had become displaced. [REDACTED]</p>	W 128	<p>o. The Access Support Consent process was revised to include the access support training plan in the consent packet.</p> <p>p. The PDs/designees submitted a schedule to review each person's access needs, initiate a new informed consent as indicated, and develop plans that promote individual freedoms and rights as indicated.*</p> <p>q. The ERS I/GSA will conduct weekly environmental maintenance and environmental inspections and will report findings to ASD for resolution.*</p> <p>r. A QAPI was developed to monitor environmental and maintenance service.*</p> <p>s. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) conduct rounds to ensure individuals have access to identified areas and the environment is maintained. Findings presented to the AE Committee. Results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.*</p> <p>t. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.*</p> <p>u. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.*</p>	9/09/13 9/09/13 10/10/13 10/01/13	

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{W 129}	Continued From page 60	{W 129}	124, # 5.	9/09/13	
{W 129}	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observation, interview, client record review, and facility policy review, the facility failed to ensure the right to personal privacy for one client who was placed in restraints in front of other clients (Client 85) and for another client whose clothing was changed in a public room with the door open (Client 113). Findings: 1. Residence 44 (Unsampled Client 85) On 7/31/13 at 9:17 a.m., Client 85 was observed in Group Activity Room 1 (A) with a leather wrist-to-waist restraint which tethered both arms and hands securely to the client's sides (at the wrist) and could not be removed by the client without staff assistance. Additionally the client wore a helmet into which was incorporated a clear plastic shield (splash guard) extending down to the chin. Because of the wrist-to-waist restraint, the helmet could also not be removed by the client without staff assistance. At 9:20 a.m. a direct care staff stated there were thirteen plus clients in the room where Client 85 was restrained. Some entered the room then left, others were observed to mill about and/or sat in the small room observing the treatment of Client	{W 129}	a. Governing Body members are working with H&W Consultants to review access and informed consent processes to ensure that individual rights and freedoms are protected. b. The current Access Support Consent process has been revised and includes the access support training plan in the consent packet.* 9/09/13 c. The PDs/designees developed a schedule to review each person's access needs, initiate a new informed consent as indicated, and develop plans that promote individual freedoms and rights as indicated.* 9/09/13 d. The IPCs were added as participants to daily Program Management Meetings to identify and immediately address developing issues and trends for clients in their caseload. e. IPC duties have been realigned to promote more emphasis on program coordination, integration and monitoring, including client access to personal items and independence. f. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) conduct rounds to ensure individuals have access to identified areas and report findings to the AB Committee. Results of findings will be calculated, analyzed by the AB Staff Service Analyst and corrective action plans developed.* g. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* h. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.*	9/09/13 9/09/13 9/09/13 8/26/13 9/1/13 10/01/13.	

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(W 129)	Continued From page 61 85. Most of the clients were not engaged in an activity due to the distraction of the behavioral intervention. Client 85 remained restrained in Group 1 Activity Room, in this manner, for approximately ten minutes with no attempt by staff to relocate Client 85 to a private area. During the observation, Client 85 stood in one corner of the room closely monitored by a staff and observed watchfully by the other clients in the room. Eventually the direct care staff closest to the client asked, "You ready? You ready?" The helmet, then subsequently the wrist-to-waist restraint were removed in front of the other clients. Client 85 remained silent and drooled on himself. After wiping away the drool, the staff told Client 85 twice to "Have a seat," pushed down on the client's shoulder, and pushed Client 85 down into the chair located in that corner of the room until Client 85 was escorted out to attend day program. During interview of a second direct care staff in the Group 1 Activity Room, on 7/31/13 at 9:20 a.m., that staff stated that not only were there clients from Group 1 in the room, there were also clients from Group 2 in the room at the time Client 85 was restrained, with no effort by staff to remove him to a more private setting. When asked, this staff stated he did not know why Client 85 had not been moved to a more private location as he had arrived after the restraints were already in use. This direct care staff stated it was "preferable" not to restrain clients in front of others and said it would have been better to take the client to another more private location. This direct care staff, present in the room for most of the observation, was never observed suggesting to the other staff present that Client 85 be moved	(W 129)	W 125, #1 a. The shower chairs on 341 were immediately relocated to another area by the Shift Lead.* b. The PDs/designees assessed all residences to ensure areas were free from hazards and access issues.* c. US/designee will make rounds daily through the shift to ensure there are no hazards or access issues and items are stored appropriately. d. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) conduct rounds to ensure individuals have access to identified areas and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.* e. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* W 125, #2 a. The client telephone on 341 will be available at all times in the identified phone room. b. Training was provided to DCS on Residence 41 on phone expectations and client rights. c. The Shift Lead on 41 immediately placed the phone in the designated area to ensure client access.* d. USs/designees will make rounds on all residences to ensure the phones are available and staff encourage clients to exercise their rights to utilize the phone.* e. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to identified areas and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*	7/29/13 7/29/13 10/01/13 7/29/13 8/1/13 8/18/13 9/09/13	

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{W 129}	Continued From page 62 to a private area. Review of the 7/31/13 "Behavioral Intervention Record," showed that the client was placed in the restraints at 9:05 a.m. and the restraints were removed at 9:25 a.m. Documentation as to what had caused the beginning of the problem was that the client was "trying to leave group area," and did not want to participate in the activity which lead to grabbing and attempted biting of staff. On 8/7/13, review of the policy and procedures (P&P) provided by the facility concerning restraint use and privacy, showed that provision of privacy during restraint use was not included in the P&P on use of restraints, "Section V Restrictive Behavioral Interventions...Protecting Human Rights," revised 8/20/2010, pages 56-57, 60-62 and 69-71. The P&P titled, "Clinical Services...Number: 5-01-01...Person-Centered Planning/Treatment Services...Clinical Services Standards of Care," read, "Each client is provided care and treatment in accordance to their needs which respects their dignity, privacy...and culture." Resident 28 2. On 7/29/13 at 6:20 a.m., un-sampled client 113 was observed to be in the hall outside his room. the only clothing he was wearing was a shirt. A staff member immediately redirected Client 113 to the day room and proceeded to dress him. The day room door was open, and Client 113 was easily seen getting dress from the hallway. He was observed nude below the waist sitting on the couch while the direct care staff put underwear and pants on him. Other clients were observed in the area.	{W 129}	f. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* g. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.* W 125, #3. a. A Work Order was submitted and the door lock was changed to the outside storage area on Residence 41 was changed to ensure items are available at all times.* b. Training was provided to DCS on Residence 41 to identify client access areas. c. Training was provided to ICF DCS on Client Handbook specifically as it relates to client access. d. US/designee on Residence 41 will make rounds to ensure that outside storage area is available at all times. e. The USs/designees assessed all residences to ensure clients have access to all client activity supplies.* f. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to activity supplies and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.* g. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* h. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.* W 125, #4 a. A Work Order was submitted and the door lock on 342 Activity Storage room was changed to ensure clients have access to materials*.	10/01/13 9/09/13 9/9/13 9/9/13 8/15/13 10/01/13 7/29/13	

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{W 130}	Continued From page 64 stated that two of the three male clients also needed close supervision and there was no other staff available at the time to assist. Observations also revealed storage of both male and female personal hygiene supplies in the female bathroom, and no personal hygiene supplies stored in the male bathroom. Residence 29 2. On 7/30/13 at 6:45 a.m., Client 130 entered the bathroom with Direct Care Staff. The client used the commode without closing the stall door or being prompted to do so. Staff left and returned with a shirt and asked the client, while seated if he liked the one she had chosen for him. Staff failed to verbally prompt the client to shut the door or shut the door for him. Review of the client's Independent Life Skills tool dated 7/15/13, revealed that Client 130 required verbal prompts to shut the bathroom door. Residence 41 3. Client 1 was observed on 7/29/13 at 12:45 p.m., sitting in the group room in an arm chair. Three I staffs were in the room and 2 other clients. A direct care staff was standing next to her. At 12:50 p.m., the client's gastrostomy (opening into the stomach) tube and the connection port were exposed from underneath her blouse. The client at that point, pulled her blouse over the tubing. At 12:55 p.m., the client was restless and moving	{W 130}	f. US/designee provided training to DCS to ensure of knowledge of client access areas. g. PAs/Designees provided training to all Shift Leads on "Environmental Guidelines for ICF Programs" which includes the expectation that client living areas are unlocked h. The "Rounds Team" (Governing Body, Program Management, USs, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to identified areas and report findings to the AB Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. i. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS. j. The IPC will audit monthly to ensure access consents are current and notify PD for follow up W 125, #6 a. Door to hall leading to dining room and Tub room on 423 was unlocked immediately. b. The phone on 423 was relocated to the ledge so the clients would have continual access. c. US/designee on 423 will monitor during daily rounds to ensure doors remain unlocked during specified times. d. The USs/designees assessed all residences to ensure clients have access to kitchen, tub rooms and phones e. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to identified areas and report findings to the AB Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. f. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS. * ###(see inserted page 66a and b)#####*	9/9/13 9/9/13 10/01/13 7/29/13 7/29/13 8/15/13 10/01/13
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			W 125, #6 g. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.*		
			W 125, #7 a. US immediately unlocked the tub room, phone room and kitchen on 428. *	7/29/13	
			b. Lock was removed from 428's phone room	9/5/13	
			c. DCS on 428 were reminded at change of shift huddle that kitchen, tub rooms and phone room are to be accessible to clients based on individual access assessment.	7/29/13	
			d. PA/Designee trained Shift Leads on on 428 on "Environmental Guidelines for ICF Programs" which includes the expectation that client living areas are unlocked and well organized.	9/7/13	
			e. Individual access was reviewed with DCS on 428 as part of the focus calendar.	8/13/13	
			f. The Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) to ensure that client areas are accessible and well organized during ongoing rounds conducted on the residence. Results of findings will be calculated, analyzed by the AE Analyst and reviewed by Governing Body for follow up.		
			h. The USs/designees assessed all residences to ensure clients have access to kitchen, tub room and phones.*	8/15/13	

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			i. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* j. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.*	10/01/13
			W 125, #8. a. All signs posted in reference to phone hours on Residence 30 were immediately removed.*	9/09/13
			b. A sign-in sheet on 430 was removed from the phone room.	8/09/13
			c. Individual access was reviewed with 430 DCS as part of the focus calendar.	8/13/13
			d. The USs/designees assessed all residences to ensure clients have access to telephone.*	8/15/13
			e. The "Rounds Team" (Governing Body, Program Management, US, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to telephones and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Staff Service Analyst and corrective action plans developed.*	
			f. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.*	10/01/13

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{W 130}	Continued From page 65 about in the chair and the gastrostomy tube was again exposed and lying on her pant. The direct care staff member remained standing and looking at the client, however, he did not cover up the tubing. Shortly thereafter, the direct care staff left the room. At 1:05 p.m., it was brought to the attention of the Licensed Staff by the surveyor that the client's gastrostomy tube was exposed for at least 10 minutes. The licensed staff stated that the client at time tries to pull out the tubing and proceeded to place the tubing inside the client's pants.	{W 130}	W 125, #9. a. A Work Order was immediately submitted to have lock on workshop Room 36 changed.* b. The DTAC Coordinator trained DCS on expectation to keep Room 36 unlocked during work hours.* c. Vocational Assessment for Client 150 was revised to reflect the current work hours d. Vocational Supervisor met with DCS to review the hours of operation for all classrooms including Room 36 and explained the importance of providing independent access to clients.* e. CPS initiated development of an Orientation sheet for float instructors/aids f. Vocational Supervisor/designee will provide orientation to DCS who are assigned as a float to classroom 36 and review class description, class schedule and clients' training plans. g. Vocational Supervisor/designee will conduct rounds to ensure all clients have access to enter their work sites during their work schedules.* h. The "Rounds Team" (Governing Body, Program Management, USs, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to identified areas and report findings to the AB Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed	8/21/13	09/09/13
{W 136}	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on clinical record review, family interview and staff interviews, the facility failed to ensure 1 of 20 core sampled clients (Client 90) had the opportunity to attend social religious activities and Clients 171, 184, 151, 162, and 150 had not attended off campus activities or on campus special events. Findings: Residents 23 1. Client 90 was admitted to the facility on 8/21/12. He currently attended a day activities program five days a week and had gone on	{W 136}		9/06/13	10/10/13

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{W 136}	Continued From page 66 several outings to fast food resturants by van. A review of Client 90's IPP Narrative (Individual Program Plan) dated 9/19/12 documented "Religious Preference: [redacted]. [Client's Name _____] will be afforded the opportunity to attend religious services every Sunday". On 8/1/13 at 5:15 p.m., an interview was conducted with Client 90's mother. She expressed concern that she was unable to verify if Client 90 had the opportunity to attend church, she explained that on four occasions she asked various unit staff members if Client 90 had the opportunity to attend church services, she stated "I was never able to obtain an answer". On 8/6/13 at 10:00 a.m., an interview was conducted with the residence Unit Supervisor and a direct care staff. The direct care staff stated that Client 90 had never attended church since admission. The staff members were unable to confirm if Client 90 was given the opportunity to attend church services. On 8/7/13 at 9:00 a.m., during a second interview with the Unit Supervisor she explained that there was no documentation to address Client 90 being given the opportunity to attend church. Residence 31 2. On 8/7/13, review of the records of Sampled Clients 171 and 184 revealed that neither individual had gone off grounds or attended a special on grounds activities since February 2013.	{W 136}	W 125, # 10. a. Housekeeper immediately cleaned the identified refrigerator on Residence 30.* b. US/Designee immediately identified and removed Client food from the refrigerator and discarded it.* c. Sign posted on staff refrigerator indicating that no client food is to be stored in staff refrigerator and that all food must be clearly labeled. d. US on Res 30 developed a schedule for Shift Leads to clean refrigerator(s) once per week including discarding any unlabeled food. e. US initiated training for Res. 30 staff on Nursing Procedure 5.04 "Food Supplements" f. Unit Supervisor initiated training for Res. 430 DCS on storage of snack and supplements g. PA initiated training for US and Shift Leads on "Environmental Guidelines for ICF Programs" h. US/designee assessed refrigerators on all units to ensure that no client food is stored in staff refrigerator and that all food is clearly labeled.* i. US/designee will monitor refrigerators during environmental rounds to ensure they are clean and that client and staff food are stored separately.* 125, # 11 a. US/Designee immediately unlocked the visitor's room and tub room on Residence 30.* b. US/Designee submitted a Work Order for signs on Res 30 to correctly identify rooms.*	7/30/13 7/30/13 7/30/13 7/30/13 9/07/13 9/07/13 9/09/13 7/29/13 9/9/13	

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{W 136}	Continued From page 67 Residence 30 Client 151 3. Client 151 had not been taken to any community based activities between the dates of 3/10/13 and 7/17/13. On 3/9/13 Client 151 was taken on a van ride drive through McDonald's. A van ride in not considered a community integration activity. There was no documentation as to why Client 151 was not allowed to go inside McDonald's and order a meal, sit down and eat it. When asked, the activity director stated that she had received an email in January of 2013 directing that each individual be taken to the community at least once per month. This Program 4 Directive was not individualized and FDC failed to facilitate Client 151's participation in the community. The activity director stated that Client 151 should have been given more community based outside activities. The recreation therapist went on to say that if she sees that an individual has not been taken to the community for a while she will try to give them a community opportunity. Client 162: 4. Client 162 had not been taken to any community based activities between the dates 5/4/13 and 7/24/13. Record review revealed Client 162's IPP dated 8/16/12 read: "enjoys going to movies, going on outings and she also enjoys going shopping." Client 162: "prefers to go bowling and she like to participate in Special Olympics. She enjoys water sports and swimming."	{W 136}	c. US/Designee submitted a Work Order to adjust the volume on the doorbell on Res 30.* d. DTAC Coordinator submitted a Work Order to have lock on workshop 36 changed.* e. The DTAC Coordinator trained DCS on expectation to keep Room 36 unlocked during work hours. f. An IPP was held for Client 151; the access plan was discussed and related training implemented. g. An IPP was held for Client 162; the access plan was discussed and related training implemented. h. A Special Conference was held for Client 150; the access plan was discussed and related training implemented. i. Governing Body members are working with H&W Consultants to review access and informed consent processes to ensure that individual rights and freedoms are protected. j. The Access Support Consent process was revised to include the access support training plan in the consent packet. k. A schedule will be developed to review each person's access needs, initiate a new informed consent as indicated, and develop plans that promote individual freedoms and rights as indicated l. USs/Designees immediately assessed all identified areas to ensure that clients had access.* m. The US/designee assessed each residence to ensure clients have access to all identified areas.* n. Vocational Supervisor/designee conducts rounds to ensure all clients have access to entering their work sites during their work schedules.*	09/09/13 08/21/13 8/23/13 8/06/13 8/01/13 8/01/13 9/09/13 9/09/13 9/09/13 07/29/13 8/15/13

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{W 136}	Continued From page 68 Client 150: 5. The activity director verified that Client 150 participated in a community based coastal van ride on 6/12/13 and no other community based activity until 7/17/2013 when she attended "Friends of the Fair." Record review of Client 150's 10/11/12 dated IPP read: Client 150: "I like going on all kinds of community outings." The activity director verified that Residence 30 clients were not involved in various activities in the community (e.g.) going to parks, movies, restaurants, church, community events based on interests and choices. Insufficient staff has limited these individuals from being integrated into the community as required by this regulation. The Individual Program Coordinator (IPC), who serves as the Qualified Intellectual Disabilities Professional for Client's 150, 151 and 162 was interviewed at 9:00 AM on 8/8/13. The IPC indicated that participation in the community was limited by staff availability.	{W 136}	o. The "Rounds Team" (Governing Body, Program Management, USs, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to identified areas and report findings to the AE Committee. Results of findings will be p. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.* q. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.* 125, # 12. a. Governing Body members are working with H&W Consultants to review access and informed consent processes to ensure that individual rights and freedoms are protected. b. The Access Support Consent process was revised to include the access support training plan in the consent packet. c. A schedule was developed to review each person's access needs, initiate a new informed consent as indicated, and develop plans that promote individual freedoms and rights as indicated.*	10/01/13*	
{W 137}	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, interview, and facility document review, the facility failed to ensure the rights of clients to retain and use appropriate personal possessions and well-fitting, appropriate clothing (Clients 68, 107,	{W 137}	d. The IPCs were added as participants to daily Program Management Meetings to identify and immediately address developing issues and trends for clients in their caseload with the interdisciplinary team.* e. US immediately unlocked tub room on Residence 30.* f. The US/designee assessed each residence to ensure clients have access to tub rooms.* g. The "Rounds Team" (Governing Body, Program Management, USs, Shift Leads, IPCs) will conduct rounds to ensure individuals have access to tub rooms and report findings to the AE Committee. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.*	9/09/13 9/09/13 9/09/13 07/29/13 8/15/13	

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{W 137}	<p>Continued From page 69</p> <p>151, 162, 150, 163, 146, and two randomly-observed clients); failed to allow Client 76 to retain and wear his own clothing; and failed to ensure that clients on Residences 29 and 31 had personal possessions displayed to indicate one individual's personal space from another individual's space.</p> <p>Findings:</p> <p>Residence 28</p> <p>1. On 7/30/13 at 8:00 a.m., during the breakfast observation Client 107 was observed to walk into the dining room. As he walked into the room, his pants fell to his thighs. He was observed to reach back and pull them up as he walked, keeping his pants covering only half of his buttocks. Direct care staff immediately assisted him and straightened out his pants as he sat down in his dining chair.</p> <p>At 8:05 a.m., Client 107 got up to go to the tray line. His pants quickly fell, exposing his underwear. Staff followed closely behind him keeping one hand around his rear beltline to keep his pants up while he walked to the tray line and then to return to his seat.</p> <p>After breakfast the client put his dishes away and left the dining area. A direct care staff was walking behind him loosely holding his rear pants beltline.</p> <p>On 7/30/13 at 8:10 a.m., the Program Director stated he was surprised that Client 107 did not have a belt on and a direct care staff added that another staff went to get one.</p> <p>Residence 44</p>	{W 137}	<p>h. The facility Focus Calendar will include access related topics for review at daily shift change huddle for DCS.*</p> <p>i. The IPC will audit monthly to ensure access consents are current and notify PD for follow up.*</p> <p>W 126</p> <p>a. Money management plan for Client 150 was corrected and re-filed in the Clinical Record.</p> <p>b. DTAC Coordinator trained DCS on Client 150's money management milestone.</p> <p>c. PA/Vocational Supervisor/IPC will conduct rounds to ensure plan is being appropriately implemented.</p> <p>d. IPC will monitor the plan in the monthly progress note and follow-up with any issues as indicated.</p> <p>e. A plan has been developed to reorganize Vocational Services under CPS, which will improve the continuity of services and promote more opportunity for choice as well as provide an increased variety of paid job opportunities.</p> <p>e. A plan was developed to reorganize Vocational Services under CPS, which will improve the continuity of services and promote more opportunity for choice as well as provide an increased variety of paid job opportunities *</p> <p>f. CPS Director/Designee developed an Orientation Check list for DCS who are floating to the worksites. Vocational Supervisor/designee will meet with substitute instructors/floats prior to the start of the work session and review class description, class schedule and clients milestones using the Orientation Checklist.*</p>	<p>10/01/13*</p> <p>8/22/13</p> <p>8/22/13</p> <p>10/01/13</p> <p>10/01/13</p>

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(W 137)	Continued From page 70 2. On 7/31/13 at 11:45 a.m., during a conversation with a case worker at the local regional center, the case worker stated that Client 76's family member reported observations directly to her following weekly visits made to the facility to visit Client 76. The case worker stated this family member wanted Client 76 to be well dressed and during each weekly visit, brought clothes for him to wear during the week. According to the case worker, the family member provided particular brands of clothing she liked Client 76 to be dressed in and during each visit the client was changed into the fresh clothes which had been brought that day. The case worker stated that, "Every time we speak she has a concern with his clothes. I've been trying to address it for several months. (Client 76) puts his clothes in the garbage or dirty laundry bin so appropriate clothing often is not available." The case worker had been told by the family member that Client 76 was observed in facility provided pants (jeans) that were way too big, being held up by a belt that was too small instead of in clothes provided by family. The family member had shared multiple observations with the case worker. The case worker stated, "Undergarments often have someone's (someone else's) name on them," and were "not appearing clean...several times would be an understatement!" The family member told the case worker she observed underwear on Client 76 put on backwards with labels displaying other clients' names and the case worker went on to say that the family member recently told her she "saw his shorts were so big he had to hold (his)	(W 137)	g. Vocational Services Supervisor/Designee audited all client money management milestones to ensure appropriateness, proper implementation and documentation.* h. DCS will receive training to any changes in money management milestones.* i. IPCs will monitor money management training and document progress monthly. Concerns will be addressed at Emerging Risk Review meeting.* W127 a. One to one supervision was instituted immediately for Client 77. b. Client 77 was relocated to a separate area on one wing of Residence 44 away from other clients for their protection. c. Client 77's location provided him with his own restroom, bedroom, living room and entrance to the residence. d. Staff on Residence 44 were given specific action plan instructions regarding Client 77's expected behavior and programming as well as directions to obtain assistance by activating the Personal Alarm System (including backup system) if he displayed non-compliance with the items listed on the action plan. e. Behavioral plans and the action plan instructions were reviewed with DCS on duty and oncoming shifts. f. A plan to relocate the individual for assessment of additional service and support needs was developed in coordination with the Department of Developmental Services, Fairview Developmental Center, and Porterville Developmental Center. Client 77 was be moved to Porterville Developmental Center.	09/09/13	8/08/13 8/08/13 8/08/13 8/08/13 8/08/13 8/09/13

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{W 137}	Continued From page 71 pants up and could not play basketball!" Then the case worker expressed her frustration saying, "A belt is a Band-Aid, not a remedy!" According to the case worker, Client 76 was not being dressed consistently in family provided clothing because it was misplaced or dirty. A meeting held with the facility was held to make sure clean, personal clothes remained available to Client 76. The case manager stated that there was a way to balance access with the right to be dressed in family provided clothing. The case worker stated the issue had not been resolved. One outcome of the meeting was that a checklist was to be created and used by staff, beginning on 7/16/13, to document that Client 76 was appropriately dressed each day in the family provided clothing. The case worker said, "I have asked to see it several times. I asked this morning," and was told that the facility was to get back to her. This request was also made on 7/24/13 when the case worker sent an e-mail to the facility social worker and the Unit Supervisor (US). No response had been received from the US. The social worker responded on 7/29/13 and informed the case worker that the US was "working on the list." The social worker stated, "I just want it addressed!" and went on to state that this had been the family member's "number one complaint for a while ... It is a legitimate concern." On 7/31/13 record review showed no evidence of a checklist indicating that Client 76 was being consistently dressed in family provided clothing. On 7/31/13 at 12:05 p.m., when the US was asked if staff had used a checklist yet, she responded "No."	{W 137}	g. Ongoing assessment and review via the IPP process will be provided to ensure that Client 77's transition and future placements are based on his assessed needs. h. Monitoring of ongoing risk data (such as patterns of perpetrator/victim roles in client-to-client altercations) will be conducted and adjustment of living arrangements will be made, based on acuity needs of individuals. i. Governing Body is currently partnering with H&W Independent Solutions to revise the protocol for identifying when an individual poses a significant threat to others. As identified, the IDT will make immediate adjustments to ensure the safety of others. The IDT will review and modify behavioral support plans as indicated and assess the individual's living arrangement to determine placement in the most appropriate setting. W 128, #1 a. A Special Conference for Client 184 was held to discuss current medical status and adaptive equipment needs. Client 184's program plan was revised to discontinue use of wheelchair. b. A Follow-up meeting was scheduled to review Client 184's progress in 30 days. c. Translocation via bus will be utilized to prevent exacerbation of bursitis. Milestone to utilize bus transportation was developed for Client 184. d. DCS were trained on Client 184's new milestone and translocation plan (to ride the bus). e. The IPC will monitor progress with objective and will document results in the monthly note any concerns will be reviewed the the Unit Supervisor for action.	8/08/13	8/12/13 9/09/13 8/13/13 8/16/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P (CF/IID)			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
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{W 137}	Continued From page 72 3. On 7/29/13 at 12:10 p.m., during a random observation in the dining room, a client was observed in red pants bunched up at the ankles and hanging on the floor. The right leg hem was unraveled with the frayed edge exposed. 4. On 7/29/13 at 2:10 p.m., during a random observation in the administration building, a client was observed wearing jeans and a belt however the belt failed to hold up the client's pants. The pants were falling off and had dropped to mid-buttock with a large swath (approximately 5 inches) of boxer underwear exposed. The client was engaged in pushing a large plastic container on wheels with both hands while material, piled up at the base of the client's legs, dragged on the ground. The staff person present did not intervene in any manner. 5. On 7/29/13 at 6:30 p.m., Client 68 was observed carrying multiple dishes to an area designated for rinsing dishes, accompanied by a direct care staff. The client was having some difficulty carrying the dishes since one hand was holding up jeans (cut off below the knees) worn by the client that were too loose and were falling off. After the staff was asked who the client was, the staff said to Client 68, "Like, you need a belt," to which the response was, "Someone needs to measure me tonight...I need to be measured." Client 68 continued to struggle with the dishes and hold onto his pants so they did not fall off. On 7/29/13, review of a recent "Statement of Deficiencies and Plan of Correction," with a survey completion date of 5/17/13, the corrective action plan developed by the facility to address	{W 137}	W128, #2 a. Program Assistant conducted audit of bed rails in Program 4 to ensure no other bedrails in use without assessment/consent. b. Special Conference held for Client 178 to discuss need for bedrails. c. Consents and approval obtained for use of protective bedrails for Client 178. d. Unit Supervisor/designee initiated training for Res. 31 DCS on Section IV of the HRC Manual "Protecting Human Rights". e. Unit Supervisor/Designee initiated training for Res. 31 DCS on Facility Policy 05-04-04 "Protective Devices". f. Unit Supervisor/designee will monitor to ensure that Client 178 has ongoing approval for bedrail usage. W129, #1 a. Unit Supervisor provided training to DCS on Client 85's residence on FDC 1.3.1 "Mission and Values" with emphasis on their responsibility to ensure clients are provided dignity, respect and quality of life services/treatment. b. Unit Supervisor provided training to DCS on Client 85's residence on FDC 1.3.2 "Principles and Practices" with emphasis on the staff's responsibility to protect the rights of the individuals who live at FDC by providing services and supports that build confidence, self-worth and self-determination. c. Interdisciplinary team was held to review and modify the behavioral support plan to clearly outline the appropriate location to apply and utilize highly restrictive interventions. Initiated on	8/12/13 8/13/13 9/09/13 8/30/13 8/14/13 9/09/13 9/09/13 8/12/13	

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{W 137}	Continued From page 73 Ill-fitting clothing indicated that "Clients' clothing on all residences were evaluated for fit and appropriateness. Ill-fitting...and unfashionable clothing was discarded and replaced." The shift supervisor was to ensure clients demonstrated an "attractive appearance." Residence 29 and 31 6. Random observations of clients' personal space; bedrooms on these residences, revealed that the majority of the clients' bedrooms failed to contain any personal decorative possessions, nor displayed anything of their individuality, preferences, or experiences. Bedrooms/Individual personal space was mostly shared with one to three other individuals. One's space could not be distinguished another's except for an individual's name on his/her wardrobe closet. There were no photos, bedspreads, evidence favorite colors, interests etc. that reflected the individual person. During Interviews on 8/1/13 and 8/7/13, Individual Program Coordinators on both residences acknowledged that the team could assist clients in making choices of personal items reflective of each individual's unique interests and likes. Residence 30	{W 137}	d. Residence DCS were provided training on the modifications to Client 85's plan. e. US/designee will ensure plans are carried out as written during rounds. f. Follow-up/review for staff knowledge and awareness of the standards will be incorporated into focus calendars for review at huddle/shift change meetings. g. US/designee will monitor to ensure privacy and dignity are maintained when an individual requires restrictive intervention. W 129, #2 a. New facility policies 5.3.1 Behavior Support Principles (and Glossary), 5.3.2 Behavior Support Programs and 5.3.3 Behavior Techniques and Interventions were developed and distributed. Policy 5.3.3 specifically addresses the expectation for applying restraints in a manner that protects clients' privacy and dignity. b. A summary of new and key items from those policies were distributed to DCS emphasizing positive behavioral approaches. c. Staff Development provided "Dignity In Care" training to all Residence 28 DCS. d. Acting US/SPT provided "Privacy" training to all Residence 28 DCS. e. US/designee will monitor during rounds to ensure that privacy and dignity are maintained during ADLs. f. US/Designee provided training to DCS on client 113's ADLs with emphasis on privacy and dignity at all times.* g. USs conducted an audit of client wardrobes to ensure ample clothing was available to all clients on 28, including client 113.*	9/09/13 8/30/13 9/09/13 8/28/13 8/19/13 10/10/13 09/09/13	

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{W 137}	Continued From page 74 Client 151 7. On 7/29/13, Client 151 was observed with the leather torn off one of her white tennis shoes in Residence 25 Room 33 approximately 2:00 pm. On 7/30/13 at 8:40 a.m. DTAC staff stated that the torn leather shoe observed on Client 151 was unacceptable. The DTAC staff person stated that she went to the Fashion Center and obtained a pair of white Velcro shoes size 5. The surveyor observed this staff member put these shoes on Client 151. Client 151 had no opportunity to choose or shop for her own shoes. At this time, three different women in the same Group Room were wearing the exact same white Velcro tennis shoes. [REDACTED] (Refer to W247 No opportunity for choice and self-management.) Client 162 8. On 7/31/13 at 8:43 am Client 162 was observed ambulating in the hallway towards the dining room in a shoe that her foot was coming out of on the side. When asked why Client 162 was wearing this shoe that did not properly fit, the direct support staff stated that this shoe was Client 162's choice. When asked the Registered Nurse, RN, stated and verified that Client 162's shoe was "inappropriate" for her to walk in. RN stated that the shoe did not fit Client 162 correctly for her to walk steady. [REDACTED]	{W 137}	W 130, #1 a. Training was initiated for DCS on "Dignity In Care", 8/28/13 b. "Privacy" training was provided to Client 188 and 130's DCS. 8/19/13 c. US identified gender specific restrooms on 431. 8/15/13 d. "Female" and "Male" signs were installed on designated bathroom doors on 431. 8/22/13 e. 431 DCS received training on gender specific restrooms. 8/15/13 f. 431 DCS oriented clients to the gender specific restrooms. 8/15/13 g. 431 grooming supplies relocated to the correct gender specific restrooms. 8/15/13 h. Rounds team (Governing Body; Program Management, US, Shift Leads, IPC) will conduct rounds to ensure privacy and dignity are maintained during ADLs. Results of findings will be calculated, analyzed by the AB Analyst and presented to AB committee for follow up.* 8/28/13 W130, #2 a. Training was initiated for DCS on "Dignity In Care". 8/19/13 b. "Privacy" training was provided to Client 130's DCS.		

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W 138	<p>Continued From page 76</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that each client is dressed in his or her own clothing each day.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure that one unsampled client (Client 76) was ensured the right to be dressed in the client's personal clothing each day. This failure resulted in the Client 76 being dressed in other clients' clothing as well as dirty and sometimes ill fitting clothing which at times interfered with the client's daily activities.</p> <p>Findings: Residence 44</p> <p>1. On 7/31/13 at 11:45 a.m., during a conversation with a case worker at the local regional center, the case worker stated that Client 76's family member reported observations directly to her following weekly visits made to the facility to visit Client 76. The case worker stated this family member wanted Client 76 to be well dressed and during each weekly visit, brought clothes for him to wear during the week. According to the case worker, the family member provided particular brands of clothing she liked Client 76 to be dressed in and during each visit the client was changed into the fresh clothes which had been brought that day.</p> <p>The case worker stated that, "Every time we speak she has a concern with his clothes. I've been trying to address it for several months. The case worker stated that, "(Client 76) puts his</p>	W 138	<p>c. US/designee reviewed documentation to ensure the opportunity was provided.</p> <p>d. Since client was transitioning into the community the new care providers were informed of family preferences.</p> <p>e. A family satisfaction survey was developed and will be available to families on an ongoing basis. The results will be shared with the Governing Body and improvement plans implemented to ensure ongoing communication with families and to ensure their needs and issues are addressed in a timely manner.</p> <p>W136, #2</p> <p>a. A new protocol was developed and implemented to address expectations related to quantity and quality of community outings.</p> <p>b. Active Treatment Coordinators have been designated on each program and are responsible for the development and implementation of active treatment projects to be integrated facility-wide, with emphasis on promoting choice and independence in all environments.</p> <p>c. Rehabilitation Therapist conducted an audit of Activity Records and provided training to DCS on Client 171 and 184's residence on documentation of community outings.</p> <p>d. Client 171 attended a community outing on 8/15/13. A community outing is scheduled for September.</p> <p>e. Client 184 attending a community outing on 8/29/13. A community outing is scheduled for September.</p> <p>f. US will monitor to ensure that all clients are provided regular opportunities to participate in community activities.</p>	8/23/13 8/29/13 9/09/13 9/09/13 9/09/13 9/09/13 8/15/13 8/29/13	

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W 138	<p>Continued From page 77</p> <p>clothes in the garbage or dirty laundry bin so appropriate clothing often is not available." The client also mixed clean clothes in piles on the floor with his dirty clothes.</p> <p>During the 11:45 a.m. interview, the case worker stated she had been told by the family member that Client 76 was observed in facility provided pants (jeans) that were way too big, being held up by a belt that was too small instead of in clothes provided by family. There were multiple observations shared with the case worker. The case worker stated, "Undergarments often have someone's (someone else's) name on them," and were "not appearing clean...several times would be an understatement!" The family member told the case worker she observed underwear on Client 76 put on backwards with labels displaying other clients' names and went on to say that the family member recently told her she "saw his shorts were so big he had to hold (his) pants up and could not play basketball!" Then the case worker expressed her frustration saying, "A belt is a Band-Aid, not a remedy!"</p> <p>According to the case worker, Client 76 was not being dressed consistently in family provided clothing because it was misplaced or dirty. A meeting held with the facility was held to still make sure clean, personal clothes remained available to Client 76. The case manager stated that there was a way to balance access with the right to be dressed in family provided clothing.</p> <p>The outcome of the meeting was that a checklist was to be created and used by staff, beginning on 7/16/13, to document that Client 76 was appropriately dressed each day in family provided clothing. The case worker said, "I have asked to</p>	W 138	<p>W136, #3</p> <p>a. A new protocol was developed and implemented to address expectations related to quantity, quality and location of community outings.</p> <p>b. Active Treatment Coordinators have been designated on each program and are responsible for the development and implementation of active treatment projects to be integrated facility-wide, with emphasis on promoting choice and independence in all environments.</p> <p>c. Rehabilitation Therapist conducted an audit of Activity Records which revealed that Client 151 participated in a community outing in July and August and a trip is scheduled for September.</p> <p>d. US will monitor to ensure that all clients are provided regular opportunities to participate in community activities.</p> <p>W136, #4</p> <p>a. A new protocol was developed and implemented to address expectations related to quantity and quality of community outings.</p> <p>b. Active Treatment Coordinators have been designated on each program and are responsible for the development and implementation of active treatment projects to be integrated facility-wide, with emphasis on promoting choice and independence in all environments.</p> <p>c. Rehabilitation Therapist conducted an audit of Activity Records and provided training to DCS on Client 162's residence on documentation of community outings.</p> <p>d. Client 162 attended a community outing in July and August. A community outing is scheduled for September.</p> <p>e. US will monitor to ensure that all clients are provided regular opportunities to participate in community activities</p>	<p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p>

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W 138	Continued From page 78 see it several times. I asked this morning," and she was told that the facility was to get back to her. This request was also made on 7/24/13 when the case worker sent an e-mail to the facility social worker and the Unit Supervisor (US). No response had been received from the US. The social worker responded on 7/29/13 and informed the case worker that the US was "working on the list." The social worker stated, "I just want it addressed!" and went on to state that this had been the family member's "number one complaint for a while ...it is a legitimate concern." On 7/31/13 record review showed no evidence of a checklist indicating that Client 76 was being dressed in family provided clothing. On 7/31/13 at 12:05 p.m., when the US was asked if staff had used a checklist yet, she responded "No."	W 138	W136, #5 a. A new protocol was developed and implemented to address expectations related to quantity and quality of community outings. b. Active Treatment Coordinators have been designated on each program and are responsible for the development and implementation of active treatment projects to be integrated facility-wide, with emphasis on promoting choice and independence in all environments. c. Rehabilitation Therapist conducted an audit of Activity Records and provided training to DCS on Client 150's residence on documentation of community outings. d. Client 150 attended a community outing in July and August. A community outing is scheduled for September. e. US will monitor to ensure that all clients are provided regular opportunities to participate in community activities. f. Clinical Director is revising staffing input to a work group with DCS representatives from each area to review staffing deployment and make recommendations to ensure staffing levels are met within the center. g. The PD will develop a protocol to provide a center wide staffing coordinator that will ensure scheduling of resources are effectively deployed to meet the minimum staffing guidelines and the acuity needs of the clients. h. US and Program Management Team meet daily to review the staffing needs for the next 24 hours, including using available staff, return to work staff, limited duty assignments. Adjustments are made as needed. i. NCs review staffing assignments and deployments daily and make adjustments to meet residence acuity needs. j. NCs meet weekly to review facility staffing for the upcoming week and make plans for coverage as needed.	9/09/13 9/09/13 9/09/13 9/09/13	
W 144	483.420(c)(2) COMMUNICATION WITH CLIENTS, PARENTS & The facility must answer communications from clients' families and friends promptly and appropriately. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a prompt and appropriate response to an inquiry made by a client's mother (Client 90) regarding his opportunity to attend religious services. This lack of response by the facility resulted in the family member's repeated requests for information and frustration in not obtaining it.	W 144			

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W 144	Continued From page 79 Findings: Residence 23 Client 90 was admitted to the facility on 8/21/12. He currently attended a day activities program, five days a week and has gone on outings by van. A review of Client 90's IPP Narrative (Individual Program Plan) dated 9/19/12 documented "Religious Preference: [REDACTED] [Client's Name _____] will be afforded the opportunity to attend religious services every Sunday". On 8/1/13 at 5:15 p.m., an interview was conducted with Client 90's mother. She expressed concern that she was unable to verify if Client 90 had the opportunity to attend church, she explained that on four occasions she asked various unit staff members if Client 90 had the opportunity to attend church services, she stated "I was never able to obtain an answer". On 8/6/13 at 10:00 a.m., an interview was conducted with the residence Unit Supervisor and a direct care staff. The direct care staff stated that Client 90 had never attended church since his admission. The staff members were unable to confirm if Client 90 had the opportunity to attend church services. On 8/7/13 at 9:00 a.m., during a second interview with the Unit Supervisor she explained that there was no documentation to address Client 90 being given the opportunity to attend church.	W 144	W137, #1 a. A belt was immediately obtained for client 107. b. Client 107 was re-measured for appropriate clothing sizes and an inventory was completed to ensure that he had an adequate amount of appropriate clothing in the proper size. c. US ordered additional clothing for Client 107 including belt. d. Staff will assist Client 107 in trying on clothing when new clothes are received to ensure proper fit. e. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.* f. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues. g. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. h. The Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will observe clients for appropriate dress during ongoing rounds in various locations on campus. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. i. US/designee will ensure all clients are measured for appropriate clothing size and an inventory will be completed to ensure an adequate amount of appropriate clothing in the proper size.* j. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*	7/30/13 8/28/13 9/02/13 8/16/13 9/01/13 10/10/13 10/10/13
{W 148}	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &	{W 148}		

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{W 148}	<p>Continued From page 80</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Client 12's conservator, a family member, was notified when the client had pain and a limited range of motion in her left arm; and another instance when the client had severe back pain which required a new order for pain medication and a progression of the client's condition to a lack of movement of her legs.</p> <p>Findings: Residence 41</p> <p>1. During a telephone interview on 8/5/13 at 4:10 p.m., with Client 12's conservator, she stated that she kept a record of when the facility notified her of circumstances that affected her sister, the client's condition. [REDACTED]</p> <p>During a review of the clinical record, the following was noted: On 7/10/13 at 2:20 p.m., documentation in the</p>	{W 148}	<p>W137, #2</p> <p>a. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues.</p> <p>b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly and belongs to them.</p> <p>c. US developed a Daily Clothing Inventory List for Client 76 to ensure that he has sufficient clothing in his wardrobe cabinet at all times.</p> <p>d. US/Designee provided training to DCS on the Daily Clothing Inventory List for Client 76.</p> <p>e. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*</p> <p>f. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.*</p> <p>g. US/designee assessed Client 76's clothing for appropriate fit and ensured that only client 76's clothing was in his wardrobe. *</p> <p>h. All clients including Client 76 were re-measured for appropriate clothing sizes and an inventory was completed to ensure that they have an adequate amount of appropriate clothing in the proper size.*</p>	8/16/13 9/09/13 9/09/13 9/09/13 9/09/13 10/10/13 10/10/13	

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{W 148}	<p>Continued From page 81</p> <p>Interdisciplinary Notes (IDN) noted that the client had limited range of motion and pain in her left shoulder. The client was seen by the physician and pain medication was given. X-rays were ordered which were negative. There was no documentation that the conservator was notified.</p> <p>On 7/17/13 at 7:15 a.m., documentation in the IDN noted that the client complained of back pain and refused to get out of bed. The client was seen by the physician. X-rays of the neck, back, chest and pelvis were ordered which were all negative. However, by 5:15 p.m. the client continued to have back pain. [REDACTED]</p> <p>At 6:50 p.m., the client "refused" to move her lower extremities and by 10:20 p.m., the physician was notified that the client refused to move her lower extremities. There was no documentation that the conservator was notified.</p> <p>Requests for notifications for the conservator sister and another brother and sister were contained within the clinical record. It was noted that all family members wanted to be notified by telephone if there was a change in physical status and significant medication change. However, there was not a category to address the ordering of an x-ray to rule out conditions.</p> <p>During an interview with the Unit Supervisor on 8/6/13 at 4:25 p.m., she stated that it was not necessary to contact the conservator since the x-ray of the client's left arm was negative for a fracture. She further stated that she was under the impression that the social worker or staff on duty would have contacted the client's conservator when the client's condition worsened the evening of 7/17/13.</p>	{W 148}	<p>i. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed W137, #3</p> <p>a. An ad hoc committee, which includes clinical an administrative staff, as well as clients, has been formed to address clothing issues.</p> <p>b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly</p> <p>c. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*</p> <p>d. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.*</p> <p>e. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed*</p>	8/16/13 9/01/13 9/09/13	

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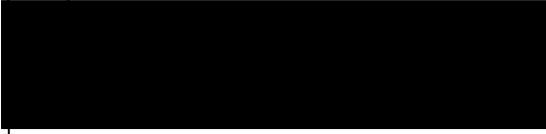
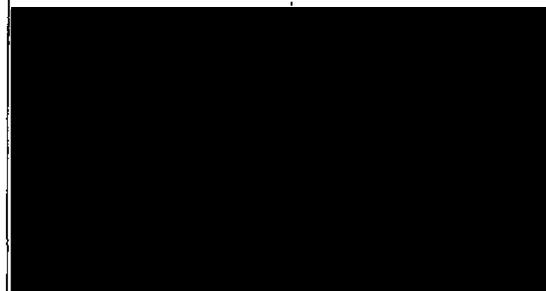
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B-WING _____		(X3) DATE SURVEY COMPLETED R. 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92628		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 149}	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure that staff followed policy and procedures for promptly identifying bruises of undetermined origin and injuries of unknown origin; for ensuring that a protective helmet was free of defects and for ensuring that there was documented treatment for a witnessed fall. The collective cluster of these events (within a month) and the staffs' negligence impacted the health, safety and welfare of the client with resultant bodily harm (Client 12.)</p> <p>The client was admitted to an outside acute care hospital with a bruise on the neck, a rib fracture of unknown length of time, a hematoma (blood clot) under the scalp, paralysis of the lower extremities and a fracture of the cervical (neck) spine. The client underwent surgery for the cervical fracture and is now a quadriplegia (paralysis of arms and legs) and has a tracheostomy (opening into the trachea) with oxygen administration.</p> <p>The survey team met with the Acting Executive Director, the Acting Clinical Director and the Director of Agency Evaluation on 8/8/13 at 4:05 p.m., and declared IMMEDIATE JEOPARDY.</p> <p>After review of the evidence of implementation of the corrective action plan on 8/9/13 at 1:35 p.m., with the Acting Executive Director, Acting Clinical Director and the Director of Agency Evaluation, the IMMEDIATE JEOPARDY remained in effect.</p>	{W 149}	<p>W137, #4</p> <p>a. An ad hoc committee, which includes clinical an administrative staff, as well as clients, has been formed to address clothing issues.</p> <p>b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly</p> <p>c. US to assign each DCS staff a caseload to include ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing.</p> <p>d. US/Designee to train DCS on the expectations of their client caseloads.</p> <p>e. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.*</p> <p>f. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed*</p>	8/16/13 9/01/13 9/09/13 9/09/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 149}	Continued From page 83 upon conclusion of the survey on 8/9/13. On 8/16/13 at 3:35 p.m., after review of the evidence of implementation of the corrective action plan, the survey team met with Acting Executive Director and the Director of Agency Evaluation and abated the immediated jeopardy. In addition, the facility failed to ensure implementation of its Client Protection Policies and Procedures when injuries of unknown origin were not identified, documented, reported immediately, and investigated (Clients 180, 193, and 182); when staff failed to document and follow reporting procedures when a client ran out of the back door of a day program which placed the client at high risk for injury (Client 184); and when the Client Protection Policy for reporting injuries of unknown origin was not in compliance with federal regulations (Client 121.) Findings:  	{W 149}	W137, # 5 a. An ad hoc committee, which includes clinical an administrative staff, as well as clients, has been formed to address clothing issues. b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. c. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly d. Level of care staff escorted Client 68 to his bedroom to change his clothing and then to the fashion center to be re-measured and to select clothing to ensure that they are properly fitted.* e. US to assign each DCS on all units a caseload to include ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing. f. US/Designee to train DCS on the expectations of their client caseloads. g. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.* h. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AB Analyst and corrective action plans developed.*	8/16/13 9/01/13 9/09/13 9/09/13 9/09/13	

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P IGF/ID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			W 137, #6 a. Social Workers contacted the families of individuals on all residences including those residing on Res. 29 and 31, requesting family photos and other personal items to decorate client bedrooms and living areas. *	10/10/13	
			b. PD provided training to US/designee on expectations that clients be assisted to obtain personal possessions which emphasize individuality and personal preferences.*	10/10/13	
			c. Purchase Orders have been initiated, including 429 and 431, to personalize client living spaces and clients are involved in selecting items of interest. *	10/10/13	
			d. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will monitor client living areas to ensure living areas reflect personal preferences, interests and likes during observations.		
			W137, #7 a. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues.	8/16/13	
			b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing.	9/01/13	
			c. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly.	9/09/13	

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/HID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			d. A shopping outing was scheduled for Client 151 to select and purchase new clothing, including shoes.	9/09/13	
			e. US provided training to DCS regarding the expectation that clients are afforded the opportunity to select their own clothing and shoes	9/09/13	
			f. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.*		
			g. Rehabilitation Therapist/DCS scheduled shopping trips for clients on 430 to have the opportunity to select clothing of their choice. **	10/10/13*	
			h. The Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will observe clients for appropriate dress during ongoing rounds in various locations on campus. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.		
			i. US/designee will ensure all clients are measured for appropriate clothing size and an inventory will be completed to ensure an adequate amount of appropriate clothing in the proper size.*	10/10/13	
			j. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*	10/10/13	

OCT 16 2013

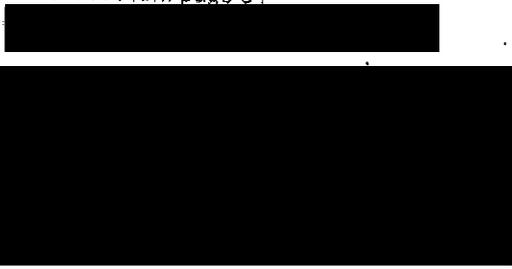
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/09/2013
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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/AID	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626
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{W 149}	Continued From page 84 	{W 149}	W137, #8 a. An ad hoc committee, which includes clinical an administrative staff, as well as clients, has been formed to address clothing issues. b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. c. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly d. Client 162's Group Leader accompanied client to the fashion center to re-measure shoe size and select new clothing and shoes. e. A shopping outing was scheduled for Client 162 to select and purchase new clothing, including shoes. f. Shift Lead conducted an audit of Client 162's shoes and clothing, discarding any that did not properly or were in disrepair. g. US provided training to DCS regarding the expectation that clients are dressed appropriately. h. Rehabilitation Therapist/DCS scheduled shopping trips for clients on 430 to have the opportunity to select clothing of their choice. ** i. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.* j. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AB Analyst and corrective action plans developed.* e. US assigned DCS caseloads that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*	8/16/13 9/01/13 9/09/13 9/09/13 9/09/13 9/09/13 9/09/13 10/10/13* 10/10/13
	Review of the client diagnoses noted that the client did not have a diagnosis of osteoporosis (brittle bones) and the current physician's orders noted that the client was not on any medications for osteoporosis. Further review of the clinical record noted a "cluster" of undetermined bruises, injuries of unknown origin, a defective protective helmet and a witnessed fall without documented medical follow up. These events occurred within a one month period from 6/16/13 through 7/19/13 as follows: 6/16/13 at 8:10 p.m. Interdisciplinary Notes (IDN): During bathing, staff noticed a 10 cm (centimeter) x 12 cm area of yellowish to light purple discoloration on the client's upper left arm. 6/16/13 at 9:30 p.m. cause of the discoloration unknown. 6/18/13 Emerging Risk Review (ERR): Review of incident attended by Unit Supervisor, Social Worker, RN Health Services Specialist, Psychiatric Technician and the Individual Program Coordinator noted that "thorough skin assessments" were not done during showering which could have possibly identified the bruise on an earlier date.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: D5G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 149}	Continued From page 85 7/1/13 at 2:50 p.m., IDN: Client had a seizure on the way to school and fell on the ground. No injuries. Seen by the physician. However, there was no documentation in the Physician Progress Notes on that date that the client was examined. During an interview on 8/2/13 at 1:20 p.m., with the Licensed staff regarding the incident, the Licensed staff stated that the client had a seizure and fell pretty hard on the sidewalk. She stated that the client put both hands out to brace herself and fell on the left side. She further stated that after a few minutes she and the client started walking back to the unit. They walked a few feet and were picked up by a passing facility bus. Licensed staff stated that the client was not injured. 7/10/13 at 2:20 p.m., IDN: Client had limited range of motion with her left shoulder. Client complained of being hurt when she lifted her left arm. 7/10/13 at 1:00 p.m., Physicians' Progress Notes: Staff reported that client had pain in her left shoulder with limitation in movement. No bruise or swelling. Assessment: pain. Pain medication. Shoulder x-ray was negative. During an interview with the Licensed staff on 8/7/13 at 2:26 p.m., she stated that on 7/10/13, the client was only able to raise her arm up half way. The Licensed staff stated that the client told her that she did not know why her shoulder was hurting. Licensed staff stated that the client only complained for one day. However, there was no documentation that the client was assessed the next day to see if she still had limited range of	{W 149}	W137, #9 a. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues. b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. c. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly d. A shopping outing was scheduled for Client 150 to select and purchase new clothing, including bras. e. US provided training to DCS regarding the expectation that clients are afforded the opportunity to select their own clothing and shoes. f. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.* g. US/designee evaluated clients 150's clothing to ensure proper fit and style that provides for dignity** h. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AB Analyst and corrective action plans developed.* i. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*	8/16/13 9/01/13 9/09/13 9/09/13 9/09/13 09/09/13* 10/10/13	

OCT 13 2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
{W 149}	<p>Continued From page 86 motion of the left arm.</p> <p>7/14/13 at 3:45 p.m., IDN: During showering, the client was noticed with discoloration behind her left ear down the nape of her neck to the start of her shoulder. There were various stages of discoloration in a 7 cm X 4 cm area, yellowish, 1cm X 3 cm dark purple and a 1 cm X 1.5 purple. Licensed staff assessment was vital signs per protocol, monitor for pain, monitor the affected area and notify physician and HSS (health services specialist) if any significant change. The assessment did not include neurological checks for the head injury.</p> <p>7/14/13 at 5:00 p.m. Physician's Progress Notes: The contusion fading at the neck scalp area was likely related to the tight fitting helmet. Observe the client. Consider helmet modification.</p> <p>During an interview on 8/9/13 at 12:50 p.m. with the licensed staff who discovered the discolorations on the client's left ear and neck, she stated that the yellowish discoloration was on the scalp area by the left ear and the two purplish areas were on the left side of the neck; however, one of the purplish areas was closer to the client's shoulder.</p> <p>During an interview on 8/9/13 at 9:50 a.m., with the Assistant Technology Specialist, he stated that he repairs and makes durable medical equipment such as helmets. He stated that upon examining the client's helmet on 7/15/13, there was a lot of hair that had adhered to the removable inner lining and on the inside of the helmet. He stated that approximately 2/3rds of the inner lining was worn and cracked. He stated that he discarded the inner lining. However, he</p>	{W 149}	<p>W137, #10</p> <p>a. An ad hoc committee, which includes clinical and administrative staff, as well as clients, has been formed to address clothing issues.</p> <p>b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing.</p> <p>c. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly</p> <p>d. A shopping outing has been scheduled for Client 151 to select and purchase new clothing, including bras of her choice. *</p> <p>e. Unit Supervisor provided training to DCS regarding the expectation that clients are afforded the opportunity to select their own clothing.</p> <p>f. Rehabilitation Therapist/DCS scheduled shopping trips for other clients to have the opportunity to select clothing of their choice.*</p> <p>g. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed.</p> <p>h. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*</p>	<p>8/16/13</p> <p>9/01/13</p> <p>9/09/13*</p> <p>9/09/13</p> <p>10/10/13*</p> <p>10/10/13</p>

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(W 149)	Continued From page 87 found a 2 inch crack on the right front of the helmet. He showed a similar hard helmet and the location of the crack which he stated had separated. He stated that he discarded the original helmet due to the crack. He further stated that staff used to send the inner lining to his department for replacement when there was a defect, but it has been sometime since he had received one. 7/15/13 at 3:45 p.m., IDN: Left ear bruise, no complaint. No signs and symptoms of pain or discomfort. Helmet repaired and replaced. 7/16/13No IDN entry 7/17/13 at 7:15 a.m., IDN: Refused to get out of bed. Complained of back pain. Notified the physician. 7/17/13 at 9:00 a.m., Physicians' Progress Notes: Complaint of back pain. Range of motion, both legs and arms, complete and no pain. "No bruise on body." X-rays ordered of cervical spine, lumbar spine, thoracic and hip. 3:00 p.m. all x-rays negative for fracture. Review of X-rays done 7/17/13 of the cervical spine, noted that the x-ray was a limited study of the cervical spine showing C1 - C3 due to client habitus (appearance/physique). (The cervical spine consists of C1 - C7). It was noted that no fracture of C1 - C3, but if symptoms persisted, a CT scan was suggested. During a telephone interview with the radiologist on 8/5/13 at 2:40 p.m., he stated that the client was lying on her back and only the upper part of the cervical spine could be seen because her	{W 149}	W137, #11 a. An ad hoc committee, which includes clinical an administrative staff, as well as clients, has been formed to address clothing issues. b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing. c. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly d. US provided training to DCS regarding the expectation that clients are afforded the opportunity to select their own clothing. e. Client 146 was re-measured for appropriate clothing sizes and an inventory was completed to ensure that he had an adequate amount of appropriate clothing in the proper size.* f. Shift Lead conducted an audit of all clients including Client 146's shoes and clothing, discarding any that did not fit properly or were in disrepair. * g. Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will ensure that clients are appropriately dressed in clothing of their preference and provided opportunities for independence. Results of findings will be calculated, analyzed by the AE Analyst and corrective action plans developed. h. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.* W138 a. An ad hoc committee, which includes clinical, administrative staff, and clients, has been formed to address clothing issues.	8/16/13 9/01/13 9/09/13 10/10/13 09/09/13* 10/10/13 8/01/13

OCT 16 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/09/2013
NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626	
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(W 149)	<p>Continued From page 88</p> <p>shoulder got in the way. He stated that a CT scan was recommended.</p> <p>7/17/13 at 5:15 p.m., IDN: Continued to have back pain and an order for stronger pain medication was obtained.</p> <p>7/17/13 at 6:50 p.m., IDN: Client refused to move her legs</p> <p>7/17/13 at 10:20 p.m., IDN: Client refused to move her legs and physician was notified.</p> <p>7/18/13 at 12:10 a.m., Physicians' Progress Notes: Exam. Noted two faint purplish discoloration 4 cm X 2 cm and 4 cm X 1.5 cm on the client's left lumbosacral (lower back) area. Staff reported client refused to move since yesterday. Transferred to an outside acute care hospital to rule out spinal injury, cause unknown.</p> <p>7/18/13 at 5:45 a.m., IDN: Client returned from hospital.</p> <p>7/18/13 at 9:00 a.m., IDN: Physicians' Progress Notes: Scans of the spine and pelvis were negative at the outside acute care hospital. Acute care hospital discharge note dated 7/18/13 at 3:14 a.m., noted that the lumbar spine x-ray and pelvis x-rays were negative for fractures.</p> <p>7/18/13 IDN: pain medication given for back pain at the following times:</p> <p>0700..Ibuprofen 400 mg (milligrams).</p> <p>0830..Ibuprofen not effective Given Acetaminophen with codeine #3.</p>	(W 149)	<p>b. Additional washer/dryers have been made available to clients to facilitate independence and improve the sustainability of clothing.</p> <p>c. Increased monitoring steps have been added by the Governing Body to ensure that clients are dressed properly for weather and occasion, and that clothing fits properly</p> <p>d. US/designee assessed Client 76's clothing for appropriate fit and ensured that only client 76's clothing was in his wardrobe. *</p> <p>e. US/Designee provided training to DCS on the Daily Clothing Inventory List for Client 76.</p> <p>f. US assigned DCS on all units a caseload, that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing and provided training on expectations.</p> <p>i. US/Designee will ensure all client's, including client 76's, clothing is well fitted and clean during daily rounds and will set expectations and coach staff when they see ill-fitting or unclean clothing on clients and that DCS maintain their assigned caseload.*</p> <p>j. The Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) will conduct rounds to ensure individuals have access their own clothing and are dressed in well-fitting clothing of their choice and report findings to the AE Committee.*</p> <p>k. Shift Lead/Designee will monitor clients daily before they leave the residence to ensure proper dress and any corrective actions will be taken immediately.*</p> <p>h. US assigned DCS caseloads on all units that includes ordering clothing, maintaining a sufficient amount of clothing, and proper fitting clothing, and provided training in expectations.*</p>	<p>9/01/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>9/09/13</p> <p>10/10/13</p>

08/09/2013

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			<p>W144</p> <p>a. A family satisfaction survey was developed and will be available to families on an ongoing basis. The results will be shared at AE Committee and improvement plans implemented to ensure ongoing communication with families and to ensure their needs and issues are addressed in a timely manner.</p> <p>b. Unit Supervisor provided training to DCS for Client 90 on expectations for church attendance.</p> <p>c. DCS ensured Client 90 was afforded the opportunity to attend church services and documented his attendance or his preference to refuse the service.</p> <p>d. US/designee reviewed documentation to ensure the opportunity was provided.</p> <p>e. Since client was transitioning into the community the new care providers were informed of family preferences by the Program Assistant.</p> <p>f. US/designee will monitor during management debriefing meetings to ensure all clients are given the opportunity to attend religious activities of their choice.</p> <p>g. CPS provides monthly calendars of available opportunities for attendance at church/religious events.</p> <p>h. Rehabilitation Therapists monitor Activity Records monthly and findings are reviewed by US/PPD for follow up.</p>	<p>9/01/13</p> <p>8/23/13.</p> <p>8/23/13</p> <p>8/23/13</p> <p>8/29/13.</p> <p>9/09/13</p>	

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			i, IPCs monitor event participation and document such in monthly notes.		

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{W 149}	Continued From page 89 1000..Acetaminophen with codeine not effective. MD informed. New order given Tizanidine HCL 4 mg. 1800 (6 p.m.)..Ibuprofen 400 mg at 1730 (5:30 p.m.).. at 1900 (7:00 p.m.) mildly effective. 2200 (10:00 p.m.)..No complaint of pain. 7/19/13 IDN: 0630..No complaint of back pain during the night. 1000..No complaint of back pain. Lying on back. Refused to be moved. 7/19/13 at 10:00 a.m., Physicians' Progress Notes: Client's condition has not changed. Client refuses to get up and does not move extremities much. Referred to the outside acute care hospital for follow up. Review of the outside acute care hospital records, noted that the client was admitted [REDACTED]. Noted was a bruise on the client's neck. X-rays/scans showed the following: a right rib fracture of unknown length of time, a hematoma (blood clot) under the scalp, paralysis of the lower extremities and a fracture of the cervical (neck) spine at the C4 to C5 level. The client had surgery for the cervical fracture upon admission and had a postoperative diagnosis of a quadriplegia (paralysis of arms and legs). [REDACTED] During an interview with a Licensed staff on 8/9/13 at 12:50 p.m., she stated that the client complained of back pain at least a week before	{W 149}	##(see inserted page 90a and b for Tag 144) W148 [REDACTED] b. A letter was mailed to all families along with the Request for Notification form to indicate their wishes to be notified of events or changes in condition. * c. Training was initiated for all DCS, including DCS on Residence 41 regarding the Request for Notification form. * d. US/designees on all residences will monitor notification to family/representatives when an unusual occurrence or other change of condition occurs.* e. Clinical Program and AE Risk Managers will monitor General Events Reports to ensure notifications to authorized representatives has been documented.* f. US will monitor for change of condition and notify DCS/Social Workers to initiate family contact.* g. Any change of condition and subsequent notification will be reviewed at Management Debrief meetings for follow up action.* h. A family satisfaction survey was developed and will be available to families on an ongoing basis. The results will be shared with the Governing Body and improvement plans implemented to ensure ongoing communication with families and to ensure their needs and issues are addressed in a timely manner.*	8/08/13 7/15/13 9/09/13 9/01/13

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 HARBOR BOULEVARD COSTA MESA, CA 92626
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{W 149}	<p>Continued From page 90</p> <p>7/17/13. She stated that she told the medication nurse on two occasions; however she checked the MAR (medication administration record) and did not see the entries. When asked why she did not document the client's symptoms in the IDN, she stated that she thought the medication nurse would have done it.</p> <p>During an interview with the Licensed Shift Lead for p.m. shift on 8/8/13 at 7 a.m., he stated that the client was walking and her usual self on 7/15/13 and 7/16/13. He stated that the client was on general supervision and was free to walk about the residence; however, staff were to know her whereabouts at all times.</p> <p>[REDACTED]</p> <p>[REDACTED] He stated that on 7/17/13, the day shift and the p.m. shift staffs did not report to him that the client had two bruises on her back. The bruises were discovered by the physician.</p> <p>During an interview with the Licensed Shift Lead for day shift on 8/6/13 at 6:45 a.m., she stated that the client was quieter and did not walk much on 7/16/13. She stated that the client was on general supervision which meant that the staff knew where the client was at all times. visual every 10 to 15 minutes when not in the group area and 30 minutes at night. She stated that the client has had no altercation with other clients. She stated that the client wore a hard helmet during waking hours and soft helmet at night.</p> <p>[REDACTED]</p>	{W 149}	<p>W 149, #1</p> <p>a. Client 12 was discharged to a sub-acute facility.*</p> <p>a. The following facility policies were revised: 5.1.1 Standards of Care (skin integrity), 5.5.5 General Event Reporting Attachment A – Types of Incidents (falls), 5.5.5 General Event Reporting Attachment I – Level I and II Review of GERs.</p> <p>b. A template was developed to prompt Level I reviewers (supervisors) with specific questions that will elicit a more thorough investigation of events, leading to more comprehensive and immediate corrective actions.</p> <p>c. DCS staff received training on FDC 5.1.1 Clinical Standards of Care and 5.5.5 General Event Reporting - Attachment A Types of Events (falls)</p> <p>d. DCS received training on 10.02 Helmet Usage, 10.06 Neuro Checks, 11.01 Temporary Conditions (new), 11.02 Client Injury Assessment and Intervention (new), 11.04 Daily Care Flow Sheets (new).</p> <p>e. DCS staff received training on FDC 5.4.2 Change of Condition, FDC 5.5.5 General Event Reporting – Minor Unknown Injury reporting, and NP 10.06 Neuro Checks.</p> <p>f. The following Nursing Procedures were developed or revised; 10.02 Helmet Usage, 10.06 Neuro Checks, 10.09 Vital Signs, 11.01 Temporary Conditions (new), 11.02 Client Injury Assessment and Intervention (new), 11.04 Daily Care Flow Sheets (new).</p> <p>g. A Protection From Harm Manual was developed and distributed to all facility staff. The manual contains an overview of Client Protection principles as well as a hierarchy of processes in place to prevent and/or mitigate client risks and serves as a reference for managers/supervisors and DCS.</p>	8/08/13 9/09/13 9/09/13 9/09/13 9/09/13 9/09/13 9/09/13 9/09/13

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{W 149}	<p>Continued From page 91</p> <p>[REDACTED]</p> <p>During an interview on 8/2/13 at 1:20 p.m., with a Licensed Staff, she stated that she noticed the week prior to 7/17/13, the client was guarding her left side and worried that maybe the client was going to have a stroke. She stated that she told other staff that something was not right with the client. There was no documentation of those concerns in the IDN.</p> <p>During an interview on 7/30/13 at 10:00 a.m., with a Licensed Staff, she stated that on 7/15/13 and 7/16/13, the client carried out normal activities and was ambulatory.</p> <p>The facility failed to ensure that staff implemented or timely implemented the following policies and procedures:</p> <p>Client Protections, General Event Reporting, Types of Events, 5.5.5 Attachment A, Issue 25-8/13.</p> <p>"Injuries of Unknown origin--An injury should be classified as an "injury of unknown origin" when both the following conditions are met:</p> <p>a. The source of the injury was not observed by any person and the source of the injury could not be explained by the client; and</p> <p>b. The injury is suspicious because of the extent of the injury, or the location of the injury, or the number of injuries observed at one particular point in time, or the incidence of injuries over time".</p> <p>Section 5 Clinical Services - Residential, Issue 18-11/11 5.5 Client's Safety 5.5.3 Supervision of Clients</p>	{W 149}	<p>h. A Problem/TC/Temporary Support Plan Log was developed and implemented to ensure DCS demonstrate continuity in documentation of identified health issues/injuries.</p> <p>i. DCS received training on the Problem/TC/Temporary Support Plan Log. Use of the Log will be monitored by the Unit Supervisor.</p> <p>j. A Daily Care Flow Sheet was developed and implemented to provide a more efficient tracking mechanism for DCS to document important ADL services/supports throughout the client's day.</p> <p>k. DCS received training on the Daily Care Flow Sheet. Use of the Daily Care Flow sheet will be monitored by the Unit Supervisor.</p> <p>l. A Physical Observation and Documentation Checklist was developed and distributed to residence staff to assist DCS in assessing, notifying appropriate people, and documenting injuries or other changes in condition.</p> <p>m. DCS received training on the Physical Observation and Documentation Checklist. Use of the checklist will be monitored by the Unit Supervisor.</p> <p>n. A Change In Usual Self/Behavior document was developed and distributed to residence staff to assist DCS staff in more capably assessing individuals' care on an ongoing basis.</p> <p>o. The IPCs and Health Service Specialists (HSS) were added as participants to daily Program Management Meetings to facilitate identification of and immediately address developing issues and trends for clients in their caseload.</p>	<p>9/01/13</p> <p>9/09/13</p> <p>8/19/13</p> <p>9/09/13</p> <p>8/09/13</p> <p>8/09/13</p> <p>8/12/13</p> <p>8/26/13</p>	

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{W 149}	Continued From page 92 General Supervision: Clients with general supervision have assigned staff who know the whereabouts of their assigned clients at all times and make periodic checks/contacts in order to provide assistance or guidance, as needed while individuals engage in activities. Health Care/Nursing Procedure Manual, Nursing Procedure Number 7.01, Revised Date: 09/12 Bathing, Various 1V. Shower #8: "...Observe skin condition and color during cleaning to assess skin integrity." Health Care/Nursing Procedure Manual, Nursing Procedure Number: 10.06, Revised Date: 04/13 Neurological Check: "A Physician's order is not necessary to do a neurological check. An assessment of the neurological system should be completed whenever there is suspected head injury or impaired neurological responses". Health Care/Nursing Procedure Manual, Nursing Procedure Number 10.02, Revised Date: 04/13 Helmet Usage Procedure: 1. "All helmets need to be inspected prior to each use to ensure that they are clean and in good repair. Check for defects or damage, i.e, tears in lining, worn areas, rough areas, stretched leather, loose fittings, etc. If any defect is found, the helmet is not to be used. Any defects in helmet, including broken buckles, should be reported to Rehab Engineering" "Licensed staff is to check for proper application/circulation initially and during helmet use." Due to the facility's failure to ensure that the client was not subjected to neglectful physical harm, IMMEDIATE JEOPARDY was declared on	{W 149}	p. An audit of the Emerging Risk Review process was conducted to ensure expectations are being met for quality analysis and action plan development and to ensure thoroughness of investigation. The Governing Body reviewed the findings and developed improvement plans for addressing identified issues. q. An audit of DCS' adherence to Nursing Procedures 11.01 Temporary Conditions and 11.02 Client Injury Assessment and Intervention was conducted to ensure expectations are being met for assessment and documentation of injuries and other physical conditions. r. A Quality Assurance Performance Improvement (QAPI) log was established to continue monitoring of DCS adherence to assessment and documentation procedures. s. The PM&R Department conducted an audit of medical and behavioral helmets to ensure cleanliness, proper fit, and proper function. t. A Quality Assurance Performance Improvement (QAPI) log was established to continue monitoring of helmets. The Governing Body reviewed the findings and developed improvement plans for addressing identified issues. u. The Medical Director established a protocol to ensure that when the quality of an imaging study is compromised, the technician will immediately inform the ordering physician for further evaluation and management. v. Management/Supervisor/Case Coordinator rounds were revised to include topics specific to client injury assessment, intervention, and documentation.	8/09/13 8/31/13 8/01/13 8/23/13 8/23/13 9/09/13 8/15/13

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{W 149}	Continued From page 93 8/8/13 at 4:05 p.m. On 8/16/13, at 3:35 p.m., the survey team accepted the facility corrective action plan. The correction action plan consisted of the following elements: All employees were sent an e-mail regarding initiation of an interim protocol for immediate assessment and intervention for injury of unknown origin, any fall/suspected fall, seizure activity. Completed on 8/8 Executive Committee met with Program Management and Unit Supervisors and provided direction regarding implementing the interim protocol. Completed 8/8 All Unit Supervisors immediately initiated training with all level of care staff currently on duty to implement the protocol 8/8/13. Follow up training completed by 8/15 Direction was provided to Program staff to assure that all individuals with existing injuries receive on going assessment and treatment with documentation by level of care staff at least every shift until the condition is resolved. Completed 8/8 Residence Managers initiated training with direct care staff regarding Neurological Checks NP 10.06 and Temporary Conditions, Section 11 Documentation Guidelines Item 11. D.6 Initiated 8/9. Follow up training to be completed by 8/15 Process will be implemented for CNS Dept. to audit a sample of nursing documentation to ensure that the guidelines for Neurological checks and Temporary Conditions are followed	{W 149}	w. An ad hoc committee comprised of medical, health care, clinical and administrative staff was formed to adopt a comprehensive Falls Prevention program. The Fracture/Fall Risk Assessment has been revised to focus on the falls aspect of assessment. It includes a scoring/weight aspect to assist the ID Team in identifying clients at moderate and high risk for falls and care planning accordingly. x. Facility rounds conducted by Governing Body/Program Management/Unit Supervisor/IPC's were revised to include assessment, intervention, and documentation of injuries per facility protocol. y. The IPC's and HSS' were added as participants to daily Program Management Meetings to identify and immediately address developing issues and trends for clients in their caseload. z. The Program Risk Manager will monitor each GER during the Level II Review to ensure that Level I guidelines are followed and that a thorough investigation has been completed. aa. AE Director/designee will monitor each GER during the Level III Review to ensure that Level I guidelines are followed and that a thorough investigation has been completed. bb. The Governing Body will review GERS during daily debriefing meetings and make recommendations for additional administrative investigation as indicated.	9/09/13 8/15/13 8/26/13	

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW DEVELOPMENTAL CENTER D/P ICF/IID			STREET ADDRESS, CITY, STATE, ZIP CODE 2601 HARBOR BOULEVARD COSTA MESA, CA 92626		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 149}	<p>Continued From page 94 per procédure. Complete 8/9</p> <p>The interim protocol for immediate assessment and intervention will be revised along with guidelines for assessing, reporting and documenting injuries at the time of discovery. Initiated 8/9 with follow up training to be completed by 8/15</p> <p>An interim memo was sent regarding Facility policy 5.5.5 General Event Reporting..Attachment A Types of Events, to include a new requirement for initiation of a General Event Reporting for all falls whether the individual is injured or not. Completed 8/9</p> <p>The Rounds Team (Governing Body, Program Management, Unit Supervisors, Case Coordinators) will conduct rounds in client areas daily to monitor for injuries and ensure assessments, intervention and documentation has been completed per protocol. Coaching and mentoring will be initiated as issues are identified. Completed 8/9</p> <p>The supplemental survey tool will be revised to include mentoring data for these topics during rounds and presented to the Governing Body by the Agency Evaluation Committee meetings. Completed 8/9.</p> <p>A process will be implemented for Agency Evaluation to audit a sample (30 ...2 per Individual Program Coordinators) of Emerging Risk Review (ERR) meeting minutes to ensure that trends and patterns related to injuries, falls and change of conditions, have been analyzed and appropriate action plans developed to reduce/eliminate identified risks. Completed 8/9</p>	{W 149}	<p>W149, #2</p> <p>a. DCS assessed and monitored abrasion for change in condition and provided treatment and documented in IDNs until healed.*</p> <p>b. DCS assessed all clients for injury, documented and provided treatment as indicated.*</p> <p>c. US provided training to all DCS, including staff that was with client 180 during her appointment, on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention". *</p> <p>d. US provided training to all DCS including staff assigned to Client 180's residence on Facility Policy 5.5.5, Attachment A "Minor Injury Reporting".</p> <p>e. PD/PA/US/IPC/HSS will monitor changes in client condition during the Management Debrief Meetings and follow up, as indicated.*</p> <p>f. PD/designee will review 24 hour report and NOD Report daily for changes in client condition to ensure that injuries and/or other change in condition are properly documented.</p> <p>g. Staff will assess client for injury or other physical conditions during naturally occurring times throughout the day.</p> <p>h. The facility Rounds Team (Governing Body, Program Management, US, Shift Leads, IPC) conducted focus rounds to ensure injuries were being identified, treated and documented. *</p> <p>i. Change of condition will be discussed at Emerging Risk Review meetings for potential contributing factors and any additional action plans needed.*</p> <p>j. IPCs will document pertinent information regarding change of condition in monthly notes.*</p> <p>k. AE SCC will monitor IPC notes for completeness and content.*</p>	8/06/13 8/09/13 8/09/13 8/14/13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{W 149}	Continued From page 95 Program Risk Management Review will be held monthly to review client protection data and identify trends, patterns, and system program wide concerns, action plans (training, policy/process changes, increased monitoring) will be initiated to reduce areas of identified risk. Completed 8/9 After review of the implementation of the corrective action plan, the survey team abated the IMMEDIATE JEOPARDY on 8/16/13 at 3:35 p.m. 2. On 8/6/13 at 4:50 p.m., non-sampled Client 180 had redness/abrasion on her right forehead. During a concurrent interview, Licensed Staff stated they heard that it happened [REDACTED] earlier in the day. A concurrent focus review of the client's record documented that the client was transported to and from a medical center for [REDACTED] accompanied by two staff between 7:35 a.m. and 11a.m. An Interdisciplinary Note (IDN) at 3:36 p.m. noted that the client bumped [REDACTED] several times causing some redness. The note failed to indicate which part of the client's had she had bumped. Another IDN identified right forehead redness at 9:30 p.m. There was no evidence that the physician was	{W 149}	W149, #3 a. DCS assessed and monitored leg injury for change in condition and provided treatment and documented in IDNs until healed.* b. DCS assessed all clients for injury, documented and provided treatment as indicated.* c. US provided training to all DCS including on Client 193's residence on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention".* d. Unit Supervisors provided training to all DCS including on Client 193's residence on Facility Policy 5.5.5, Attachment A "Minor Injury Reporting".* e. PD/PA/US/IPC/HSS will monitor changes in client condition during the Management Debrief Meetings and follow up as indicated.* f. Program Director/designee reviews 24 hour report and NOD Report daily for changes in condition to ensure that injuries and/or other change in condition are properly documented. g. Staff assess client for injury or other physical conditions during naturally occurring times throughout the day.* h. Change of condition will be discussed at Emerging Risk Review meetings for potential contributing factors and any additional action plans needed.* i. IPCs will document pertinent information regarding change of condition in monthly notes.* j. AE SCC will monitor IPC notes for completeness and content.*	8/08/13 8/09/13 8/14/13 9/9/13	

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{W 149}	<p>Continued From page 96 notified of this head injury, no evidence of an incident report initiated and no evidence of a Temporary Support Plan identified on the 24 hour log and no evidence of a change of condition.</p> <p>3. On 7/29/13 at 6:40 p.m., non-sampled Client 193 was observed with a red dime size mark on the front of her leg just above her foot where the tongue of the shoe she wore hit her lower leg. The client was not wearing socks. [REDACTED] On 8/6/13 at 5 p.m., the client's lower leg injury had a scab.</p> <p>On 8/7/13 a focus review of the client's record revealed no documentation of the open area on the client's leg until 8/8/13, after surveyor inquiry.</p> <p>4. 3. On 7/28/13 at 12:30 p.m. observations revealed that a non-sampled Client 121, had a large bruise on her left upper arm. [REDACTED]</p> <p>During an interview on 8/1/13 at 11:30 a.m., a Registered Nurse on Residence 29 stated that the bruise on the arm would not be reported as an injury of unknown origin because it was probably due to her insulin injection and because it did not meet the criteria of reporting of bruising greater than 5 centimeters or more and it was not on the head, breast or genital area. Asked if it was certain that the bruise was due to an injection, the nurse stated no but that the client bruised easily and she had gotten bruises on other parts of her body from the injection.</p> <p>On 7/29/13 review of the client's record indicated an interdisciplinary note dated 7/28/13 that identified "discoloration" on the client's upper left</p>	{W 149}	<p>W149, #4</p> <p>a. DCS assessed, documented and monitored affected area for any change in condition and to ensure prompt medical attention obtained.*</p> <p>b. DCS assessed all clients for injury, documented and provided treatment as necessary.*</p> <p>c. Unit supervisors provided training to all DCS including those on Client 121's residence on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention".*</p> <p>d. Unit supervisors provided training to all DCS including those on Client 121's residence on Nursing Procedure 11.01 "Temporary Conditions" and 11.02 "Client Injury Assessment and Intervention".*</p> <p>e. Unit Supervisors provided training to all DCS including those on Client 121's residence on Facility Policy 5.5.5, "General Event Reporting".*</p> <p>f. PD/PA/US/IPC/HSS will monitor changes in client condition during the Management Debrief Meetings and follow up as indicated.*</p> <p>g. Program Director/designee will review 24 hour report and NOD Report daily for changes in client condition to ensure that injuries and/or other change in condition are properly documented.</p> <p>h. Staff will assess client for injury or other physical conditions during naturally occurring times throughout the day.</p> <p>h.. Change of condition will be discussed at Emerging Risk Review meetings for potential contributing factors and any additional action plans needed.*</p> <p>i. IPCs will document pertinent information regarding change of condition in monthly notes.*</p> <p>j. AB SCC will monitor IPC notes for completeness and content.*</p>	<p>08/1/13</p> <p>8/9/13</p> <p>9/9/13</p> <p>9/9/13</p> <p>9/9/13</p>
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